50 0001

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mollie Borinsky

2. DATE OF DEATH: Jan 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2539 Loyola Southway

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 7, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Grupner
14. MOTHER'S MAIDEN NAME: Toby ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Abraham Borinsky
ADDRESS: 2539 Loyola Southway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myocardial Infarction
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28 *19*49 *to* 1-1 *, 19*50*, that I last saw the deceased alive on* 12-31 *, 19*49 *, and that death occurred at* 1:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jerome Gaber M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 1, 1950
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

JAN 1 1950

94a

50 0002 50 0002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 441

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NATHAN KANDEL

2. DATE OF DEATH: 1-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2328 Whittier Ave
c. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2328 Whittier Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 52 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Pawn Broker
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Samuel
14. MOTHER'S MAIDEN NAME: Sarah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rose Kandel ADDRESS: 2328 Whittier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
Coronary Thrombosis — 36 hours
(B)
DUE TO
Rheumatic Cardio-vascular Disease
(C) Aortic Stenosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19 44, *to* 1-1, 19 50 *that I last saw the deceased alive on* 1-1, 19 50, *and that death occurred at* 6 AM m., *from the causes and on the date stated above.*

23A. SIGNATURE: A Abrooman M. D.
23B. ADDRESS: 1109 N. Calvert St
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-2-50
24C. NAME OF CEMETERY OR CREMATORY: Sherem Tfiloh
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Benjamin Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

JAN 1 - 1950
VS 150
15678
19500000001
92c

MARGIN RESERVED FOR BINDING. LEAVE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-163 SPEERT

50 0003

BALTIMORE CITY HEALTH DEPARTMENT 420.0

CERTIFICATE OF DEATH

50 0003

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella Speert

2. DATE OF DEATH: 1/1/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 55 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3704 Garrison Boulevard Bldg.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 70
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham Becker
14. MOTHER'S MAIDEN NAME: Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel Speert
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Coma~~ Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Coronary Thrombosis & Myocardial Infarction — 2 days

DUE TO

(C) Arteriosclerotic Ht Disease — Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/25, 1949, *to* 1/1, 1950, *that I last saw the deceased alive on* 1/1/50, 19__, *and that death occurred at* 11 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. Hassel M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-2-50
24C. NAME OF CEMETERY OR CREMATORY: Sinai Israel
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Kearns Inc
ADDRESS: 2100 Eutaw Pl

VS 150

93D

MARGIN RESERVED FOR BI... PLEASE WRITE PLA... Y, WITH UNFADING INK. Every item of information should be ... lly supplied. Th... correct age is especi... important. Physi... ns: please write the causes of death clearly and ...

W-516

50 0004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

50 0004

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA WEINBERG

2. DATE OF DEATH: 1-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3815 Fairview Ave
C. Length of stay in Baltimore: 12 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-07
D. STREET ADDRESS (If rural, give location): 3815 Fairview Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Strauss
14. MOTHER'S MAIDEN NAME: Caroline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Moses Weinberg
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Scirrhous Carcinoma of the right breast & metastases
DUE TO
(B) Metastases of lungs,
DUE TO long bones & ribs
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 3/19/1942
19B. MAJOR FINDINGS OF OPERATION: Scirrhous Carcinoma of breast & metastases of axillary glands
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1942 *to* 12/31, 1949 *that I last saw the deceased alive on* 12/31, 1949 *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. Weinberger M. D.
23B. ADDRESS: 912 Brooks Lane
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-2-1950
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Hunter for Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

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Neuberger
912 ~~Roots~~ Lane

Mo 7299

3609 Edgewood Rd

50 0005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0005

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Tyler Smith Jr.

2. DATE OF DEATH: Jan-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland: U.O.A. at Thi
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memil Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-12
D. STREET ADDRESS (If rural, give location): 5303 Spring Lake Way

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug-23-1926
9. AGE (In years last birthday): 23 yrs
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BROKER one
10B. KIND OF BUSINESS OR INDUSTRY: INSURANCE none
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: G. Tyler Smith
14. MOTHER'S MAIDEN NAME: Helen E Gambrill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.
17. INFORMANT: G.T. Smith (father) ADDRESS: Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): York Rd. and Gittings Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 1, 1950 2 A m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Automobile into streetcar 27/12

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Jan 3/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Walter Williams, M.D.
25. FUNERAL DIRECTOR: Stewart Morris Co. ADDRESS: Balto.

VS 151 27480 5 0 0 1 0 0 0 1 1703

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-235

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50 0006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-28469

1. NAME OF DECEASED (Type or Print): Baby Boy Axton

2. DATE OF DEATH: 1/1/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Road 2
D. STREET ADDRESS (If rural, give location): 1213 Light St. Baltimore Md

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 12/30/49
9. AGE (In years last birthday): If Under 1 Year: Months; Days 2; If Under 24 Hours: Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Ernest Axton
14. MOTHER'S MAIDEN NAME: Irene Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 0
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage
DUE TO
(B) Cephalo-pelvic disproportion
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/30/, 1949, *to* 1/1, 1950, *that I last saw the deceased alive on* 1/1/50, 1949, *and that death occurred at* 2:00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. L. Holister M. D.
23B. ADDRESS: 1213 Light St. Balt. Md
23C. DATE SIGNED: 1/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Jan. 2-50
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem.
24D. LOCATION (City, town, or county) (State): Glenburnie Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 1950
REGISTRAR'S SIGNATURE: Thurston Williams, M.D.
25. FUNERAL DIRECTOR: Elizabeth Harle Inc.
ADDRESS: 116 E. West

VS 150

160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F534
50 0007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

447 50 0007
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Schindler
2. DATE OF DEATH: 1-1-50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-09
D. STREET ADDRESS (If rural, give location): 3708 Foster Ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 13-1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME.
11. BIRTHPLACE (State or foreign country): Germany.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Schuhmann.
14. MOTHER'S MAIDEN NAME: not known.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Daughter — ADDRESS: Rose Lange 3708 Foster Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Hypertension — Several yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-30 *, 19*49*, to* 1-1 *, 19*50*, that I last saw the deceased alive on* 1-1 *, 19*50*, and that death occurred at* 12 30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Margaret L. Sherard M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-5-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4420 Belair Rd Balto

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: Charles S. Seiler — ADDRESS: 901 S. Conkling St

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0008

M-240

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 50 0008

Registered No.

1. NAME OF DECEASED (Type or Print): Isaac Michel

2. DATE OF DEATH: Jan, 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewis Nursing Home 4203 Springdale Ave,
c. Length of stay in Baltimore 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2406 Callow, Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md.
D. STREET ADDRESS (If rural, give location)

13-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 7 1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months 5, Days 25 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): New York, N.Y.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gustave Michel
14. MOTHER'S MAIDEN NAME: Clara Strouse
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Isaac Michel — ADDRESS: 2406 Callow Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

(B) Cerebral Hemorrhage — 10 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) General + cerebral arteriosclerosis — 3 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Nov. *, 19*46*, to* Jan. 1 *, 19*50*, that I last saw the deceased alive on* 1 Jan *, 19*50*, and that death occurred at* 7:45 P.m.*, from the causes and on the date stated above.*

23A. SIGNATURE: Louis E. Wice M. D.
23B. ADDRESS: 920 St. Paul St.
23C. DATE SIGNED: 2 Jan. '50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/50
24C. NAME OF CEMETERY OR CREMATORY: Oheb Shalom
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: David Somdheim & Son — ADDRESS: 1902 Eutaw Pl.
David Somdheim & Son

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50.1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. David OLIVER MOWEN

2. DATE OF DEATH: 1/2/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH Home + Hosp. - Balto.
C. Length of stay in Baltimore: MD. 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerstown
D. STREET ADDRESS (If rural, give location): 406 Cooke Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Oct. 5, 1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST
10B. KIND OF BUSINESS OR INDUSTRY: Retired RR
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Oliver Mowen
14. MOTHER'S MAIDEN NAME: Staddelaser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Katherine Mowen
ADDRESS: 230 Summit Ave Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

(B) Generalized Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Gangrene - left foot — 1 week

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/14, 19 49, *to* 1/2, 19 50, *that I last saw the deceased alive on* 1/2, 19 50, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert E. Ewen M. D.
23B. ADDRESS: Church Home & Hosp.
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Princess Lane Cemetery
24D. LOCATION (City, town, or county) (State): Lancaster, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Kruse
ADDRESS: 8 Baltimore.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 1-4-50 RABOY 204.1

50 0010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0010

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALICE B. RABOY

2. DATE OF DEATH: 2 JAN 50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: 15-11
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3337 DOLFIELD

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: July 15, 1920
9. AGE (In years if over 1 year): 29 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis
14. MOTHER'S MAIDEN NAME: Anna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel Raboy ADDRESS: 3337 Dolfield

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

DUE TO

(B) Chronic Myelogenous Leukemia — 3 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2, 19 50, *to* 1/2, 19 50, *that I last saw the deceased alive on* 1/2, 19 50 *and that death occurred at* 8 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 5 Bolton St.
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-3-50
24C. NAME OF CEMETERY OR CREMATORY: Sherwood Holch
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 1950

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0011

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 14 50 Registered No. 0011

1. NAME OF DECEASED (Type or Print): Paul Cooper

2. DATE OF DEATH: 1-2-1950

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 3625 Dolfield Ave.

15-11

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7-26-1893
9. AGE (In years last birthday): 56 — If Under 1 Year: Months 6, Days 5 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Kitchen Equipment
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ezra Irving Cooper
14. MOTHER'S MAIDEN NAME: Libbie Cooper ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: The Seton Institute — ADDRESS: 6420 Reisterstown Rd., Balto. 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic valvular heart disease — INTERVAL BETWEEN ONSET AND DEATH: chronic?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Organic psychosis

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 29, 1949, *to* Jan 2, 1950, *that I last saw the deceased alive on* Dec 31, 1949, *and that death occurred at* 1¹⁰ A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John G Buckner M. D.
23B. ADDRESS: Seton Institute - Balto
23C. DATE SIGNED: Jan 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-3-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Newington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eutaw Pl

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0012

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

073

50 0012

Registered No.

1. NAME OF DECEASED (Type or Print): David BERLINER

2. DATE OF DEATH: 1-2-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-18
D. STREET ADDRESS (If rural, give location): 4733 Reisterstown

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-19-98
9. AGE (In years last birthday): 51
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Samuel
14. MOTHER'S MAIDEN NAME: Fanny
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Yetta Berliner ADDRESS: 4733 Reist Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

(B) Syphilitic Ht. Dis

DUE TO

(C) Syphilis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-2, 1950 *to* 1-2, 1950 *that I last saw the deceased alive on* 1-2, 1950, *and that death occurred at* 10 40 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Ruth Bleier M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-3-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jacob Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 1950 15660

30E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be ... fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and ...

50 0013 Welty 50 0013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma A. Welty.

2. DATE OF DEATH: Jan 2, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 5245 Cordelia Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5245 Cordelia Ave.,

c. Length of stay in Baltimore: 11 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5245 Cordelia Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct 16, 1862
9. AGE (In years last birthday): 87 yrs
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Union Town, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Eckard
14. MOTHER'S MAIDEN NAME: Matilda Angel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Irene Allen ADDRESS: 5245 Cordelia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis — 20 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 19 47, *to* Jan 2, 19 50, *that I last saw the deceased alive on* Jan 2, 19 50, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Lachman M. D.
23B. ADDRESS: 2322 Calloway Ave
23C. DATE SIGNED: Jan 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-5-50
24C. NAME OF CEMETERY OR CREMATORY: Church of God
24D. LOCATION (City, town, or county) (State): Uniontown, Carroll Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. R. Etchison & Son
ADDRESS: Frederick, Md.

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be ... fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and ...

50 0014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JAN 3 - 1950 0014

Registered No. 181

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Joseph O'Brien

2. DATE OF DEATH: Jan. 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Baltimore 11, Md.
C. Length of stay in Baltimore: unknown — Yrs. 2 Mos. 15 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: California
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Francisco
D. STREET ADDRESS (If rural, give location): 346 S. Ralston Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar 31, 1902
9. AGE (In years last birthday): 47 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John J. O'Brien
14. MOTHER'S MAIDEN NAME: Nellie Grogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Records, US Marine Hospital, Balto., Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pyelonephritis with uremia — Interval between onset and death: Unknown

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Following left uretero-sigmoidostomy and total cystectomy 11-15-49 (or carcinoma of urinary bladder)

DUE TO

(C) Absence of right kidney, surgical — 5 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 17, 1949, *to* Jan. 1, 1950 *that I last saw the deceased alive on* Jan. 1, 1950, *and that death occurred at* 9:50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman Tarr, M.D. M. D.
23B. ADDRESS: U.S. Marine Hospital, Balto., Md.
23C. DATE SIGNED: Jan. 1, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/50
24C. NAME OF CEMETERY OR CREMATORY: Los Angeles
24D. LOCATION (City, town, or county) (State): Los Angeles Calif

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Gold
ADDRESS: 1217 S. Ford St.

VS 150

32647

52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-220

0015 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E981 863.4

50 0015 Registered No.

1. NAME OF DECEASED (Type or Print): Samuel 200-Nooks (Noakes) 220 N-

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1721 Pennsylvania Ave.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 5, 1920
9. AGE (In years last birthday): 29 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elkridge, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Samuel Noakes, Sr.
14. MOTHER'S MAIDEN NAME: Rebecca Simms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel NoaKes, Sr. ADDRESS: 1622 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wound of abdomen
DUE TO

ANTECEDENT CAUSES
(B)
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): tavern
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1500 Laurens St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 1, 1949 6 A.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5, 1950
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles H. Alexander ADDRESS: 1200 McCulloh St., Baltimore

VS 151

166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N-200

AB-134475

CERTIFICATE CORRECTED 1-3-50

50 0016

BIRTH NO. 50 0016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 420.0

1. NAME OF DECEASED (Type or Print): William Edward Hayes

2. DATE OF DEATH: Jan. 1-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals. 4940 Eastern Ave.
c. Length of stay in Baltimore: Life-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1204 Homewood Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 15- 1888- 1889
9. AGE (In years last birthday): 61 60
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Unemployed
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): England (Maryland)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jerome
14. MOTHER'S MAIDEN NAME: Caroline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease With Failure.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26- *, 19*49 *to* 1-1- *, 19*50*, that I last saw the deceased alive on* 1-1- *, 19*50 *and that death occurred at* 11.15PM *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-2-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR: Fallone & Cohen Inc
ADDRESS: 1217 Fleet St

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

570.4 50 0017 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lewis Adolph Engel

2. DATE OF DEATH: Jany 2/1950

3. PLACE OF DEATH: A. Baltimore City, Maryland South Balto Gen'l Hos

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto Gen'l Hos

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-09
D. STREET ADDRESS (If rural, give location): 1306 W Pratt St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feby 7/1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10B. KIND OF BUSINESS OR INDUSTRY: Balto Typef Comp Corp
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Helena Marck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-28-6627
17. INFORMANT: Annie L. Engel ADDRESS: 1306 W Pratt St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

(B) Mass Splenic Flexure Colon — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic CVR Disease — ?

19A. DATE OF OPERATION: 1-2-50
19B. MAJOR FINDINGS OF OPERATION: Intestinal Obstruction
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1, 1950 *to* 1-2, 1950, *that I last saw the deceased alive on* 1-2, 1950, *and that death occurred at* 5:29 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: SBGH
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jany 6/1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry Nemiroff
ADDRESS: 4204 Ridgewood Ave

VS 150

310 37 122B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154

50 0018

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Price

2. DATE OF DEATH: 1-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 00
D. STREET ADDRESS (If rural, give location): 414 N. Arlington Ave

5. SEX: M.
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10/15/1891
9. AGE (In years last birthday): 58. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: American Refinery & Smelting Co
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Price
14. MOTHER'S MAIDEN NAME: Mariah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph Price — ADDRESS: 212 Elmora Square Pittsburg Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydronephrosis + uremia

DUE TO

(B) pressure from peritoneal cpt.

DUE TO

(C) Surgery for recto-sigmoid carcinoma.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Jan. 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of recto-sigmoid
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 Dec, 1949, *to* 1 Jan, 1950, *that I last saw the deceased alive on* 1 Jan, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Gerald A. Martin M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: Jan. 2, '50

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur
24B. DATE: Jan. 4, 1950
24C. NAME OF CEMETERY OR CREMATORY: mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Eugene Waters
ADDRESS: 661 W. Barre St. Baltimore Md

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 3 2

50 0019 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARIE JOSEPHINE KLEES

2. DATE OF DEATH: Jan. 1. 1950.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore ------. 1205
D. STREET ADDRESS (If rural, give location): 127 E. North Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug 27 1872
9. AGE (In years last birthday): 77
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Klees
14. MOTHER'S MAIDEN NAME: Mary Kindler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Harry Klees - ADDRESS: 127 E. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 mos

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/29, 1949, *to* 1-1, 1950, *that I last saw the deceased alive on* 12/31 1949, *and that death occurred at* 1:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. G. Heaton M.D. M. D.
23B. ADDRESS: Maryland Gen. Hosp.
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

K-410

50 0020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

773.0 50 0020

Registered No.

BIRTH NO. 49-11364

1. NAME OF DECEASED (Type or Print): Anna A. Szymkow

2. DATE OF DEATH: Jan. 2/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 1-04
D. STREET ADDRESS (If rural, give location): 701 Vanlil St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: June 5/ 49
9. AGE (In years last birthday): If Under 1 Year Months: 6 Days: 27 If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walter Szymkow
14. MOTHER'S MAIDEN NAME: Alverta Czyzewski
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alverta Szymkow ADDRESS: 701 Vanlil St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Dehydration and Acidosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2, 1950, *to* 1-2, 1950 *that I last saw the deceased alive on* 1-2, 1950 *and that death occurred at* 1:30P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Judith B. Laudau M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 4/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Carmel
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Ozazewski
ADDRESS: 107

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-3-20

50 0021 2353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.0

Registered No. 50 0021

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sophie (Sophia) Kelly

N-821.1

2. DATE OF DEATH: 8:05 A.M. 1/2/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 3724 Towanda Avenue (15)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 25, 1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Davis
14. MOTHER'S MAIDEN NAME: Eleanor Brennan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Records*Balto. City Hospitals
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Inanition~~ Bronchopneumonia, rt lung — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerotic cardio-vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Intertrochanteric Fracture--right hip

CERTIFICATION APPROVED BY
For Dr. William Helfrich
P. B. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

over

19A. DATE OF OPERATION: 10-6-49 11-3-49
19B. MAJOR FINDINGS OF OPERATION: Intertrochanteric Fracture
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3724 Towanda Avenue 15/12
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 4, 1949 ?m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fall down one step (probably stairstep)

22. *I hereby certify that I attended the deceased from* 10-4, 1949, *to* 1-2-, 1950, *that I last saw the deceased alive on* 1-2-, 1950, *and that death occurred at* 8:05 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: P. S. Rosen M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem
24D. LOCATION (City, town, or county) (State): 5608 Dogwood Rd Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 95 Hollins St.

VS 190 To Be Approved By The Medical Examiner

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-400

Letter in document file 50-0021- 5/2/50.

LEIGH

50 0022

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

50 0022

Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Leigh

2. DATE OF DEATH: Jan 1 — 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1942 Ridgehill Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1942 Ridgehill Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 25-1874
9. AGE (in years last birthday): 75
If Under 1 Year: Months 8 Days 7
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Duties
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? Balto. Md

13. FATHER'S NAME: Conrad Mertz
14. MOTHER'S MAIDEN NAME: Anna Marie Mertz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr Walter Leigh — ADDRESS: 1942 Ridgehill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 4-1950
24C. NAME OF CEMETERY OR CREMATORY: London Park "
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Monroe Cook Syfer — ADDRESS: 1600 W. North Ave

VS 151

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0023 50 0023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clayton T Husan

2. DATE OF DEATH: 1/2/50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3028 Brantley Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 116 W. 25th St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 15-08A
D. STREET ADDRESS (If rural, give location): 3028 Brantley Road

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66 — If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar Tender.
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aaron C Husan
14. MOTHER'S MAIDEN NAME: Sarah A Clemens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-05-8909
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 8, 1941, *to* JAN. 2, 1950, *that I last saw the deceased alive on* JAN. 2, 1950, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lloyd E. Saylor M. D.
23B. ADDRESS: 3902 Greenmount Ave.
23C. DATE SIGNED: JAN. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Lutheran Cem
24D. LOCATION (City, town, or county) (State): Threwbury Pa

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. J. Foley Sons
ADDRESS: 1318 Light

VS 150

71071 13B

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 5-24-54

50 0024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57°

50 0024

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN SANTUCCI ~~or SANTECCI~~

2. DATE OF DEATH: 1/1/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Baltimore, Inc.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-08
D. STREET ADDRESS (If rural, give location): 3708 GOUGH ST.

5. SEX: MALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: JUNE 23 1883
9. AGE (In years last birthday): 66 68 — If Under 1 Year: Months 6, Days 8 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Canton R.R.
11. BIRTHPLACE (State or foreign country): Alatri Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vincenzo Santucci
14. MOTHER'S MAIDEN NAME: Maria Scarcella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-3736
17. INFORMANT: N.De Angelo — ADDRESS: 232 S.Eaton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

(B) Generalized peritonitis

DUE TO

(C) Mesenteric thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial damage

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/30/44, *to* 1/1/50, *that I last saw the deceased alive on* 1/1/50, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: P. Leonard Dresser M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 4 1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: Frank Della Rocca — ADDRESS: 322 S.High St.

VS 150

988 47

129

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and fully supplied.

50 0025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

50 0025

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter H. Johnson ? Robert Fisher

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 2206 Pennsylvania Ave.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5/12/1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY: Apartment House
11. BIRTHPLACE (State or foreign country): Sumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Johnson
14. MOTHER'S MAIDEN NAME: Carrie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ethel J. Travers ADDRESS: 1015 Linden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Seminary latent syphilis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: CHARLES R. LAW ADDRESS: 802 Madison Ave - 1

VS 151

75081 0 0 2 4 308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 1

50 0026

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mile Tarbuk

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 102 N. Linwood Ave.
C. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 102 N. Linwood Ave.

6-01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11/22/1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Signal Depot
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Margaret Darmsteadt — ADDRESS: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: P. J. Sulzmacher M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: o 1/5/1950
24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc. — ADDRESS: 403 S. Wolfe St. Balto.

VS 151

31847

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be correct if possible. The age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0027

B-650

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0027

1. NAME OF DECEASED (Type or Print): Joseph Zahnle (Brown)

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days): Unknown

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 511 S. Caroline St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/27/1856
9. AGE (In years last birthday): 93
If Under 1 Year: Months / Days / Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Victor Dietz
ADDRESS: 525 S.Caroline St. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B) Bronchial spasm due to inhalation of smoke

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 511 S. Caroline St. 3/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 1, 1950 10:30 Pm.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Conflagration House afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: P. L. Lubinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/1950
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 403 S.Wolfe St. Balto.

VS 151 988 59 87E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01-58 vol

50 0028

Dr. Harmon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0028

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Stone

2. DATE OF DEATH: Jan. 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2516 Madison Ave.
C. Length of stay in Baltimore: 4 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2516 Madison Ave.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 18, 1881
9. AGE (In years last birthday): 68 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Mecklenberg Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Simmons
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Lossie Stone
ADDRESS: 2516 Madison Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan. 3, 1950
24C. NAME OF CEMETERY OR CREMATORY: Diamond Grove Cemetery
24D. LOCATION (City, town, or county) (State): Union Level, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

0027

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

50 0029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0029

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Spear Ayers

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2829 Windsor Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2829 Windsor Ave. 15-07B

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 17, 1859
9. AGE (In years last birthday): 90
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Ayers
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Stuart Wilcox
ADDRESS: 521 Old Orchard Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio-Vascular degeneration — ?

DUE TO

(C) Arteria-Sclerosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile dementia — 6 mo.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 2, 1949, *to* Jan. 2, 1950, *that I last saw the deceased alive on* Dec. 31, 1949, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Maurice E. Abrams M. D.
23B. ADDRESS: 3300 W. North Ave.
23C. DATE SIGNED: Jan. 3-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons.
ADDRESS: 1900 Eutaw Place

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be entered if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 50 0030

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDITH GORSUCH YOUNG

2. DATE OF DEATH: 1/1/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: 65 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-02
D. STREET ADDRESS (If rural, give location): 2906 GUILFORD AVENUE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: APRIL 8, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PHENEAS GORSUCH
14. MOTHER'S MAIDEN NAME: HANNAH E. BEAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: DR. LATIMORE G. YOUNG
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE VASCULAR DISEASE, E — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS
DUE TO CEREBRAL HEMORRHAGE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1/, 1950, *to* 1/1/, 1950, *that I last saw the deceased alive on* 1/1/, 1950, *and that death occurred at* 11:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. F. Boyd M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 4-1950
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0031

JACKSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

330

50 0031

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Estelle Jackson

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1012 Druid Hill Ave.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 9, 1912
9. AGE (In years last birthday): 37
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Randolph Boissuau
14. MOTHER'S MAIDEN NAME: Alice Crowner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M's Bessie Green
ADDRESS: Petersburg, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2- 1950, *to* 1-3- 1950, *that I last saw the deceased alive on* 1-3- 1950, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: President Hospital
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-8-50
24C. NAME OF CEMETERY OR CREMATORY: Hall Cemetery
24D. LOCATION (City, town, or county) (State): Petersburg, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley
ADDRESS: 578 W. Biddle St.

0030

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0032 50 0032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-23710

1. NAME OF DECEASED (Type or Print): PAUL HAMILTON 391.0

2. DATE OF DEATH: JAN 2 1950

3. PLACE OF DEATH:
A. State: Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 2 ~~Yrs.~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parkton
D. STREET ADDRESS (If rural, give location): Parkton, Md. Mt. Carmel Rd

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Nov. 4, 1949
9. AGE (In years last birthday): If Under 1 Year: Months 1, Days 29; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harvey Alexander Hamilton
14. MOTHER'S MAIDEN NAME: Dora Sheeler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Parents ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumococcal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Pneumococcal Septicemia — 2 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Purulent Otitis Media — 4 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1950, *to* Jan 2, 1950, *that I last saw the deceased alive on* Jan 2, 1950, *and that death occurred at* 9:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Ferling M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: Jan 3, 1949

24A. BURIAL CREMATION REMOVAL (Specify): Burial
24B. DATE: 1-5-49
24C. NAME OF CEMETERY OR CREMATORY: Jessops Methodist
24D. LOCATION (City, town, or county) (State): Sparks, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Loudon M. Brooks
ADDRESS: Sparks, Md.

VS 150

89a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly supplied.

H-543

50 0033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420 1

50 0033

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER SCOTT ADAMS

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Charles & 34th St. CAMBRIDGE ARMS APTS
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): Charles & 34th Sts.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 9, 1894
9. AGE (In years last birthday): 55 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor
10B. KIND OF BUSINESS OR INDUSTRY: Trust Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walter S. Adams
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War #1
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Florence S. Adams
ADDRESS: Charles & 34th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 day

DUE TO

ANTECEDENT CAUSES

(B) Coronary Artery Sclerosis — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: ✓
19B. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ✓
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ✓
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ✓
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ✓
21E. INJURY OCCURRED: WHILE AT WORK ☑ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? ✓

22. *I hereby certify that I attended the deceased from* Dec 23, 1949, *to* Jan 2, 1950, *that I last saw the deceased alive on* Jan ✓, 1950 *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucius E. Little M. D.
23B. ADDRESS: 10 W. Madison St.
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

3168V

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

416 Registered No. 50 0034

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theresa C. Snyder 415?

2. DATE OF DEATH: Jan. 2. 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 1531 Northgate Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Northgate Rd. Balto. Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 27-09

D. STREET ADDRESS (If rural, give location): 1531 Northgate Road

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 25. 1899

9. AGE (In years last birthday): 50

If Under 1 Year: Months, Days

If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Whitty

14. MOTHER'S MAIDEN NAME: Catherine Kennedy ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ---

(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Walter M. Snyder, 1531 Northgate Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Cardio Vascular Disease — 15-May-1947

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15-May, 1947 *to* 2-Jan, 1950, *that I last saw the deceased alive on* 1-Jan, 1950 *and that death occurred at* 12:01 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chas W. Edwards M. D.

23B. ADDRESS: 2746 Alameda

23C. DATE SIGNED: 3-Jan-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 4, 1950

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Philip Herwig Sons

ADDRESS: 2024 Orleans St.

VS 150

93c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 1/3/50

50 0035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0035

BIRTH NO. H-42878 325.5 Registered No.

1. NAME OF DECEASED (Type or Print): John Edwin (Hullihen) Jr. HULLIHEN

2. DATE OF DEATH: Jan 1, 1950.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: A.A. Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Brooklyn
D. STREET ADDRESS (If rural, give location): 901 First Street, Brooklyn

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Feb. 21, 1946
9. AGE (In years last birthday): 3 yrs
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John E. Hullihen
14. MOTHER'S MAIDEN NAME: Lucy E. Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. John E. Hullihen, 905 First Street
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronch pneumonia

DUE TO

ANTECEDENT CAUSES

(B) Amaurotic familial Idiocy.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

amaurotic

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1949, *to* Jan 1, 1950, *that I last saw the deceased alive on* Jan 1, 1950, *and that death occurred at* 6:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ann Howard, M.D. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Jan. 4, 1950
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
24D. LOCATION (City, town, or county) (State): Anne Arundel County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., 1217 St. Paul Street
ADDRESS

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-450

CERTIFICATE CORRECTED 1/3/50

50 0036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0036

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ESTELLE A. (ETHRIDGE) ETRIDGE

2. DATE OF DEATH: January 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 Alameda Blvd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 2901 Alameda Boulevard Blvd.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr. 25, 1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At. Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius H. Reising
14. MOTHER'S MAIDEN NAME: Annie L. Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: ETRIDGE
ADDRESS: John R. (Ethridge) 2901 Alameda Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO Acute Nephritis — 1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Mitral stenosis & chronic Myocarditis
DUE TO Myocardial degeneration — 2 yrs.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 5, 1947, *to* Jan. 2, 1950 *that I last saw the deceased alive on* Jan. 2, 1950 *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert G. Siegenaler M. D.
23B. ADDRESS: 1613 E. North Ave.
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook Inc., 1217 St. Paul St.
ADDRESS:

VS 150

92B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

50 0037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 r. 1

50 0037

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Fox

2. DATE OF DEATH: 1/2/1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3121 Abell Ave
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 3121 - Abell Ave
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3121 Abell Ave. 12-02

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow.
8. DATE OF BIRTH: 3/25/1861
9. AGE (In years last birthday): 88 — If Under 1 Year: Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None.
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): New Jersey.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Donnelly.
14. MOTHER'S MAIDEN NAME: Cath. McElroy.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Senfert — ADDRESS: 3121 Abell

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO

ANTECEDENT CAUSES

(B) Chronic Myocarditis — 6 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Generalized Arteriosclerosis — 6 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1945, *to* Jan. 2, 1950, *that I last saw the deceased alive on* Dec 31 1949, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas J. Mike M. D.
23B. ADDRESS: 3809 Greenmount Ave
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Pat Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. J. Fielder & Sons — ADDRESS: 1318 Light St

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0038 Bohn X 50 0038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ronald Monroe Bohn 401.3

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 38 Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Keymar
D. STREET ADDRESS (If rural, give location): Route 2

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 8, 1883
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roger Grabill Bohn
14. MOTHER'S MAIDEN NAME: Mary Alice Bostian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

ANTECEDENT CAUSES

(B) Rheumatic Pancarditis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26 *19*49 *to* 1-3 *, 19*50 *that I last saw the deceased alive on* 1-3 *, 19*50 *, and that death occurred at* 2:15 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: A. M. Powell, Jr. M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5-50
24C. NAME OF CEMETERY OR CREMATORY: Beaver Dam
24D. LOCATION (City, town, or county) (State): Union Bridge Rural Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: W. Hartley Sauer
ADDRESS: Union Bridge & New Windsor, Md

VS 150

587

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.3 50 0039

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CREETUS SHARP

2. DATE OF DEATH: Jan 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 327 W. 30th St. 12-07

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Sept 13-1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter.
10B. KIND OF BUSINESS OR INDUSTRY: Baugh Chemical Co
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hanson Sharp
14. MOTHER'S MAIDEN NAME: Margaret Irvine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Julian Sharp. ADDRESS: 1317 Minn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Cor Pulmonale
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 years approx.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/9, 1949, *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 12 30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Sheard [redacted] M. D.
23B. ADDRESS: West Balto Gen Hosp.
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/4/-50
24C. NAME OF CEMETERY OR CREMATORY: Martinton W. Va.
24D. LOCATION (City, town, or county) (State): W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Jr. ADDRESS: 1217 St Paul St

VS 150
308 17

95c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

50 0040

J520

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

50 0040

Registered No.

1. NAME OF DECEASED (Type or Print) BEULAH V. JONES

2. DATE OF DEATH 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

C. Length of stay in Baltimore 46 Yrs. ~~Mos.~~ ~~Days.~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12

D. STREET ADDRESS (If rural, give location) 531 HARWOOD AVE 27-48

5. SEX FEMALE

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7-9-1903

9. AGE (In years last birthday) 46

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK

10B. KIND OF BUSINESS OR INDUSTRY R.R.

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM O JONES

14. MOTHER'S MAIDEN NAME BEULAH STRAWINSKI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT WILLIAM JONES ADDRESS 531 HARWOOD AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASPHIXIATION

DUE TO

(B) METASTATIC CA TO LUNGS + MEDIASTINAL NODES — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.

DUE TO

(C) CARCINOMA OF RT. BREAST — INTERVAL BETWEEN ONSET AND DEATH: 10 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 12/16/49

19B. MAJOR FINDINGS OF OPERATION BIOPSY BREAST — SCIRRHUS CARCINOMA

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/8 *1949, to* 1-3 *, 1950 that I last saw the deceased alive on* 1-3 *, 1950, and that death occurred at* 12:50 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M.D. M. D.

23B. ADDRESS Maryland General Hosp.

23C. DATE SIGNED 1-3-5

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 6-50

24C. NAME OF CEMETERY OR CREMATORY Balto Cem.

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 4 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm O Cole Inc. ADDRESS 1217 St Paul St

VS 150

26647

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be furnished if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0041 G451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

592 Registered No. 50 0041

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leon Glemboski (Glembowski)

2. DATE OF DEATH: Jan. I. I950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1610 Lancaster St.
c. Length of stay in Baltimore: 35 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I6I0 Lancaster St. 2-03

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Apr. 24, I882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman
10B. KIND OF BUSINESS OR INDUSTRY: East Side Garage
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown Glemboski
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-07-93I9
17. INFORMANT: Sophia Glemboski ADDRESS: I6I0 Lancaster St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Chronic Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/3/12 *19*49, *to* 1/1/ *19*50, *that I last saw the deceased alive on* 12/31/49, *19*, *and that death occurred at* 7:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Mitchell F. Rumsey M. D.
23B. ADDRESS: 1816 E. East Ave
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 4, I950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook Inc.
ADDRESS: I2I7 St. Paul St.

VS 150

602 84

131B

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

50 0042 50 0042

B500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

470 1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Bohn

2. DATE OF DEATH: 1-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 715 Warlem Ave. 17-03

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1872 Nov. 23
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Baltimore Transit
10B. KIND OF BUSINESS OR INDUSTRY: Transportation
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Reubin Bohn
14. MOTHER'S MAIDEN NAME: Alice Weant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Daughter Mrs Alice Heilman
ADDRESS: 715 Warlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 10-15 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29, 1949, *to* 1-1, 1950, *that I last saw the deceased alive on* 1-1, 1950, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Margaret L Sherrard M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Lucille Williams N.S.
25. FUNERAL DIRECTOR: MacNabb & Son
ADDRESS: Catonsville, Md.

VS 150
26649
94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be referred to if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0043

BIRTH NO. W445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

50 0043

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES M. WILHELM

2. DATE OF DEATH: 1/3/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): OD 168 S. COLLINS AVE
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: BALTO. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-08
D. STREET ADDRESS (If rural, give location): 168 S. COLLINS AVE 29

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 12/5/1873
9. AGE (In years last birthday): 76 77 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Fire Dept.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm. WILHELM
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: CATHERINE W. McCANN — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

(B) Cardio Vascular Renal Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February *1949, to* 1/3 *, 1950, that I last saw the deceased alive on* 1/2 *, 1950, and that death occurred at* 7:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Alvin H. Carruthers M. D.
23B. ADDRESS: 4709 Fredericks Ave
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mac Nabb & Son — ADDRESS:

MAC NABB FUNERAL HOME
1310

VS 150
60098

50 0044 50 0044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. A 153 Registered No.

1. NAME OF DECEASED (Type or Print): MARY PAWLAK (MARYANNA-PAWLAK) — DATE OF DEATH: 2 Jan 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1013 Binney St
C. Length of stay in Baltimore: Life — 56 Yrs. 11 Mos. 11 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1013 Binney St. — B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md
D. STREET ADDRESS (If rural, give location): 1013 Binney St 1-04

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: Nov. 22-1893 — 9. AGE (In years last birthday): 56 — If Under 1 Year: Months 1, Days 11 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Balto. Md — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Stanislaus Kawalewski — 14. MOTHER'S MAIDEN NAME: Pauline Strzynski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service): NONE — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: John Pawlak — ADDRESS: 1013 Binny St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Cardio Vascular Disease

DUE TO

(B) Debilitation & Emaciation &

DUE TO

(C) Carcinoma of Cecum.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fecal Fistula Multiple-Canal

19A. DATE OF OPERATION: May 1949 — 19B. MAJOR FINDINGS OF OPERATION: Carcinoma Cecum - Fistulae — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Jan 2, 1950, that I last saw the deceased alive on Jan 2, 1950, and that death occurred at 8 20 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Melvin F. Sanowski M. D. — 23B. ADDRESS: 2711 Custer Ave — 23C. DATE SIGNED: Jan 2 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: Jan 7, 1950 — 24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cem. — 24D. LOCATION (City, town or county) (State): 1300 Hudek Ave - Balto

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Stephen J. Fialkowski Inc — ADDRESS: 1000 S. Kenwood Ave

VS 150 77087 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be referred to if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P420

0045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.0 50 0045 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Richardson

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Whitemarsh, Md.

D. STREET ADDRESS (If rural, give location): Ebenezer Rd.

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: May 10th, 1881

9. AGE (In years last birthday): 68 — If Under 1 Year: Months 7, Days 23, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Batimore County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Robertson

14. MOTHER'S MAIDEN NAME: Matilda Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Roberta Blunt — ADDRESS: Ebenezer Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

DUE TO

(B) Cardiac failure

DUE TO

(C) Arteriosclerotic HT dis.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Cirrhosis of liver

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3, 1950, *to* 1-3, 1950, *that I last saw the deceased alive on* 1-3, 1950 *and that death occurred at* 1 50 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ruth Bleier M. D.

23B. ADDRESS: Sinai Hosp

23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 1/7/50

24C. NAME OF CEMETERY OR CREMATORY: Ebenezer

24D. LOCATION (City, town, or county) (State): Stemmers Run, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Bartlett Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

124B

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0046

50 0046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY J. GEATTY

2. DATE OF DEATH: Jan 1 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4211 Raspe Avenue
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 4211 Raspe Ave. 26-01

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Nov. 30th, 1875
9. AGE (In years last birthday): 74 — If Under 1 Year: Months 1, Days 1; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Albert T. Geatty
14. MOTHER'S MAIDEN NAME: Mary Nonemaker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-01-6733
17. INFORMANT: Mrs. Sally Dawson ADDRESS: 4211 Raspe Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 20 1/2 yrs.

DUE TO Cardiovascular Renal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/20, 1948, *to* 1/1, 1950, *that I last saw the deceased alive on* 12/27, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. J. Battaglia M. D.
23B. ADDRESS: 5829 Belair Rd.
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Legerdon Funeral Home
ADDRESS: 7401 Belair Rd.

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0047

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

502.1 50 0047

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH ANN BRADY

2. DATE OF DEATH: Jan. 1/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 620 St. Ann's ave.
C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 620 St. Ann's ave. 9-08

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 24, 1866
9. AGE (In years last birthday): 83
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Brady
14. MOTHER'S MAIDEN NAME: Julia Kavanagh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Mary Behan ADDRESS: 443 Illchester ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility — INTERVAL BETWEEN ONSET AND DEATH: ✓

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis — Unknown

DUE TO

(C) Chronic Bronchitis — Unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26, 1949, *to* 1/1, 1950, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles R. Goodbrow M. D.
23B. ADDRESS: 2923 St Paul St
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. D. Evans & Son, Inc.
ADDRESS: 118 N. Mt. Royal Ave. 931

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

13630

Dr. Chas. R. Goldsborough
2923 St. Paul street
Be. 2256

5323

50 0048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

50 0048

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GERTRUDE HOLTZ STOCKSDALE

2. DATE OF DEATH: January 1,1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1625 E. North Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1625 E. North Avenue

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 2, 1873
9. AGE (In years last birthday): 76
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Holtz
14. MOTHER'S MAIDEN NAME: Jennie Zouck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. J. L. Forestall
ADDRESS: 511 Cording Avenue - 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage 12/26/49 - 6 days
DUE TO
(B) Arteriosclerotic thrombosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Goiter -

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 46 *to* January 1 19 50 *that I last saw the deceased alive on* Jany 1, 19 50 *and that death occurred at* 3:50 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: K. Trangott M. D.
23B. ADDRESS: 1623 E. N. Avenue
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0049 V 230 B 650 M 460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 0 50 0049

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH A. H. VOGT - (BROWN - MILLER)
Sarah Vogt

2. DATE OF DEATH: 1/2/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital.
C. Length of stay in Baltimore: 65 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1413 N. Broadway #13 8-07

5. SEX: Fe
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed.
8. DATE OF BIRTH: Dec 4, 1861
9. AGE (In years last birthday): 88
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Sapp.
14. MOTHER'S MAIDEN NAME: Mary Skinner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Harry H. Brown
ADDRESS: 1413 N. Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) due Anasarca	Several Wks
	(B) Hypertensive Cardio Vascular Disease	unknown
DUE TO	and auricular fibrillation	unknown
ANTECEDENT CAUSES	(C) Arteriosclerotic heart disease	unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Hypostatic pneumonia	72 hrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29, 1949 *to* 1-2, 1950, *that I last saw the deceased alive on* 1-2, 1950, *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Candler M. D.
23B. ADDRESS: Maryland General Hosp
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

93D

50 0050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. 50 0050

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Marie Winneberger

2. DATE OF DEATH: 1-2-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2133 Chelsea Terrace #16

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-3-1890
9. AGE (In years last birthday): 59 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10B. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Winneberger
14. MOTHER'S MAIDEN NAME: Catherine Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-07-8647
17. INFORMANT: Miss Grace Boehl — ADDRESS: 3023 Weaver Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Central accident~~ Pulmonary infarctions — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular renal disease — ? years

DUE TO

(C) Diabetes mellitus — unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Anemia — Multiple visceral ~~Hypertrophic anemia~~ infarct — unknown

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22, 1949 *to* 1-2, 1950 *that I last saw the deceased alive on* 1-2, 1950, *and that death occurred at* 3 20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Cadle M.D.
23B. ADDRESS: Md. Gen'l Hosp
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150 --
236 80

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0051

F520

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

50 0051

Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS FRANCIS FINK

2. DATE OF DEATH: January 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's
C. Length of stay in Baltimore (Yrs. Mos. Days): 41

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2300 W. Mosher St. 16-05

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 29, 1883
9. AGE (In years last birthday): 66 yrs.
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ Foreman Shop
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Trans.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? Pensioner

13. FATHER'S NAME: Jacob Fink
14. MOTHER'S MAIDEN NAME: Sarah Reiter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-10-0352
17. INFORMANT: Miss Edna M. Fink
ADDRESS: 2300 W. Mosher St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Papillary adenocarcinoma, recto-sigmoid

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 8, 1949, *to* Jan. 2, 1950, *that I last saw the deceased alive on* Jan. 2, 1950, *and that death occurred at* 12:45 pm., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1-4-50
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

33245

46D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0052 CERTIFICATE CORRECTED 1/6/50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 50 0052 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edwin P McCollom

2. DATE OF DEATH: JANUARY 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanatarium
c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 101 W. Lombard St. 4-01

5. SEX: MALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: June 22, 1866 (~~July 14, 1865~~)
9. AGE (In years last birthday): 83 (~~84 yrs.~~) If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Collection Agent (rtd)
10B. KIND OF BUSINESS OR INDUSTRY: FARM MACH.
11. BIRTHPLACE (State or foreign country): Molene, Ill.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert McCollom
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Matthew M. McCollom ADDRESS: 1435 Spring Rd. Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage c left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 22 days

DUE TO

ANTECEDENT CAUSES

(B) Generalized Arterio-sclerosis — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia, bilateral — 48 hrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 14, 1949, *to* JANUARY 3, 1950, *that I last saw the deceased alive on* JAN. 2, 1950, *and that death occurred at* 1:09 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Crem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

25272

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

50 0053

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine J. Dengler

2. DATE OF DEATH: Jan 2nd 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2316 E. Federal St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Yrs. Mos. Days — Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2316 E. Federal St

8-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 7th 1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Melchior Metz
14. MOTHER'S MAIDEN NAME: Eva Hock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Dengler
ADDRESS: 2316 E. Federal St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of the Breast — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs ago

DUE TO

ANTECEDENT CAUSES

(B) Ca of the Rt Lung

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Ca of the Liver

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension
Heart Disease

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: Ca of the Breast left
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1941, 19__, *to* Jan, 1950, *that I last saw the deceased alive on* Jan 2, 1950, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: F. Bed Rujicka M. D.
23B. ADDRESS: 600 N Patterson Park Ave
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5th 1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leo S. Loch
ADDRESS: 1701-03 N. Patterson Park Ave

VS 150

Dr Rujicka

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420. 1 50 0054

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOPHIE BERMAN

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3006 Oakley Ave
C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3006 Oakley Ave 27-17

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH
9. AGE (In years last birthday): 70 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathan
14. MOTHER'S MAIDEN NAME: Lebby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Herman Soter — ADDRESS: 3312 Clarks Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO

ANTECEDENT CAUSES

(B) General arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1947, *to* Jan 3, 1950, *that I last saw the deceased alive on* Jan 2, 1950, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Bernard J. Cohen M. D.
23B. ADDRESS: Marlborough apts
23C. DATE SIGNED: 1-4-50.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel
24D. LOCATION (City, town, or county) (State): Southern Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc. — ADDRESS: 2100 Eutaw Pl.

VS 150 -1

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Bernard Cohen
Marlborough apts
Ma 4300

50 0055 F540

50 0055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. FLORENCE ANNA FINLEY

2. DATE OF DEATH: 1/3/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALT. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4306 FORREST VIEW AVE.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: MAR. 16-1912
9. AGE (In years last birthday): 37 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: FRANK C. Kilchenstein SR.
14. MOTHER'S MAIDEN NAME: ADelAIDe E MACKINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Carville Finley — ADDRESS: 236 N.W. 21st St. Miami

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) MALIGNANT HYPERTENSION

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/16, 1949 *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 12:00 noon *from the causes and on the date stated above.*

23A. SIGNATURE: J A Roberts M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck — ADDRESS: 5305 Harford

VS-150

102

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5415
50 0056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. 50 0056

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William W. Sullivan

2. DATE OF DEATH: 1/3/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 West Balto. Gen Hosp.
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 902 W. Baltimore St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2/5/1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: B & O R R
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Philip T. Sullivan
14. MOTHER'S MAIDEN NAME: Madora Dorsey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): –
(If yes, give war or dates of service): –
16. SOCIAL SECURITY NO.: –
17. INFORMANT: Mrs Ruth A. Sullivan
ADDRESS: 902 W. Baltimore St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: approx 15 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Vascular disease — ?

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-18-49 19, *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 12:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Shear M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem.
24D. LOCATION (City, town, or county) (State): 2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 90 Hollins St

VS 150

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8 3a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

50 0057

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John A. Lewrenz

2. DATE OF DEATH: Jan. 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 422 Lyndhurst St.
C. Length of stay in Baltimore 55 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 422 Lyndhurst St. 20-07

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 23, 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months 7 Days 10
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ice Business
10B. KIND OF BUSINESS OR INDUSTRY: OWN
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert J. H. Lewrenz
14. MOTHER'S MAIDEN NAME: Augusta Zaminski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W 1
16. SOCIAL SECURITY NO.: 215-28-2458
17. INFORMANT: Ethel M. Lewrenz
ADDRESS: 422 Lyndhurst St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, splenic flexure, colon, metastatic — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-12-49
19B. MAJOR FINDINGS OF OPERATION: Metastatic CA. colon
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26-49, 19__, *to* 1-3-50, 19__, *that I last saw the deceased alive on* Jan. 2, 1950, *and that death occurred at* 2 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Raesin M. D.
23B. ADDRESS: 206 S. Filmore St.
23C. DATE SIGNED: 1.4.50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7, 1950
24C. NAME OF CEMETERY OR CREMATORY: St. Paul's Evan. Luth.
24D. LOCATION (City, town, or county) (State): Violetville, Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph F. Cole
ADDRESS: 1913 W. Baltimore St.

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50 0058

50 0058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SHADIE ~~Sadie~~ Manning

2. DATE OF DEATH: Jan. 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1208 Harford Ave.
c. Length of stay in Baltimore (Yrs. Mos. Days): 21 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1208 Harford Ave. 10-01

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: aug 14-1897
9. AGE (In years last birthday): 52. If Under 1 Year: Months 9. Days. If Under 24 Hours: Hours. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): S.C
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Peterkin
14. MOTHER'S MAIDEN NAME: Salley Peterkin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mellie Miles ADDRESS: 1229 Harford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: W. J. Mc Clafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E. Preston St

93D

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W426 50 0059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14 50 0059

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha Walker

2. DATE OF DEATH: 1/2/50 3:30 am

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bar. Wi. Ba Home 1317 - Madison Ave.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY 2214 - Hunter St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 12-04

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-21-1877
9. AGE (In years last birthday): 72 73 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dom
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Gloucester Co. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Phillip Walker
14. MOTHER'S MAIDEN NAME: Julia Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thomas Pearl ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular-Renal

DUE TO

(B) Cancer - Uremia, — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(C) Congestive Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31 *,* 19~~49~~ *, to* 1/2 *,* 19~~50~~ *, that I last saw the deceased alive on* 12/31 *,* 19~~49~~ *, and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: M. Jackson M. D.
23B. ADDRESS: 600 Madison Ave
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Rayner (Sanders) ADDRESS: 1312 1/2 E. Preston St

VS 150

77087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MS--133528 50 0060 50 0060

BIRTH NO. H400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

197 Registered No.

1. NAME OF DECEASED (Type or Print): Allen Hill

2. DATE OF DEATH: 1-1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 15 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 635 Mosher St. Zone 17 14-02

5. SEX: Male
6. COLOR OR RACE: N egro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 6, 1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: HOTEL
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Burton Hill
14. MOTHER'S MAIDEN NAME: Sudie Branch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records-- ~~4940 Eastern Ave.~~ ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sarcoma metastatic of heart, lungs, and chest

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 12-5-49
19B. MAJOR FINDINGS OF OPERATION: Sarcoma--right shoulder
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-17- *, 1949, to* 1-1- *, 1950, that I last saw the deceased alive on* 1-1- *, 1950 and that death occurred at* 4:20 AM *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: 1-4-1950
24C. NAME OF CEMETERY OR CREMATORY: Franklin
24D. LOCATION (City, town, or county) (State): Virginia Va

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: Sanders 1412 E Preston St

VS 150 55E

72087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G652 50 0061 50 0061

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 445

Registered No.

1. NAME OF DECEASED (Type or Print): Evelyn Irene Garonzik

2. DATE OF DEATH: Jan. 2/50

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1844 Wilkens Ave.

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1844 Wilkens Ave. 19-04

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 18, 1916
9. AGE (In years last birthday): 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Fulkoski
14. MOTHER'S MAIDEN NAME: Mamie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Benjamin Garonzik, 1844 Wilkens
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant hypertension 1/yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) None.

DUE TO

(C) None

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2, 1949, *to* 1/2, 1950, *that I last saw the deceased alive on* 1/2, 19__, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Wilk M. D.
23B. ADDRESS: 3030 Lt. Chas Ave
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 5/50
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Winfrey Williams M.D.
25. FUNERAL DIRECTOR: Harry Rietze
ADDRESS: 4101 Edmondson Ave.

VS 150

102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0062

H156

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31

50 0062

Registered No.

1. NAME OF DECEASED (Type or Print): John M. Huebner

2. DATE OF DEATH: Jan. 2nd. 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3 S. Payson St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): no
C. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3 S. Payson St. 20-03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 5th. 1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRODUCE DEALER
10B. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Adam Huebner
14. MOTHER'S MAIDEN NAME: Martha McNally

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jennie A. Huebner — ADDRESS: 3 S. Payson St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Arteriosclerotic C.V.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1946, *to* Jan, 1950, *that I last saw the deceased alive on* 1/2, 1950, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Found M. D.
23B. ADDRESS: 3325 Frederick Ave
23C. DATE SIGNED: 1/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 5th. 1950
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1-4-50
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Geo. E. Benger Jr.
ADDRESS: 1512 Hollins St. Balto. Md.

VS 150

15661

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E532
50 0063

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 50 0063

Registered No.

1. NAME OF DECEASED (Type or Print): James A. Entwistle

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 2901 Grey Manor Terrace Z 22 Co.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 4, 1906
9. AGE (In years last birthday): 43 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Room Op.
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Entwistle
14. MOTHER'S MAIDEN NAME: Elizabeth D. Edmondson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. — ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Obliterative Coronary Sclerosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: R B Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5, 1950
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: Roland L. Fisher
ADDRESS: 2112 Dundalk Ave.

VS 151

442 4V 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 50 0064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0064

1. NAME OF DECEASED (Type or Print): Harriet Minnick

2. DATE OF DEATH: 1-2-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (22) — Dundalk
D. STREET ADDRESS (If rural, give location): 22 Broadship Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 2-18-1882
9. AGE (In years last birthday): 67 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Cooper
14. MOTHER'S MAIDEN NAME: Nancy Ballard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY CARCINOMA

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1949, *to* 1-2, 1950, *that I last saw the deceased alive on* 1-2, 1950, *and that death occurred at* 5:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel R. Scalia M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 5, 1950
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Timothy Williams, M.D.
25. FUNERAL DIRECTOR: Roland L. Fisher
ADDRESS: 2112 Dundalk Ave

VS 150

47D

50 0065

R 200

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-1

50 0065

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Roche

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 610 Linnard St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): no
C. Length of stay in Baltimore: 64 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 Linnard St. 16-08

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 15, 1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? Ireland.
13. FATHER'S NAME: John. Roche
14. MOTHER'S MAIDEN NAME: Bridget Donelan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Richard Slater — ADDRESS: 610 Linnard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis

DUE TO

ANTECEDENT CAUSES

(B) Senility & arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1950, to Jan 2nd 50, that I last saw the deceased alive on Jan 2, 1950 and that death occurred at 1 P m., from the causes and on the date stated above.

23A. SIGNATURE: M. P. Byerly M. D.
23B. ADDRESS: 3033 W North Ave
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5 1950
24C. NAME OF CEMETERY OR CREMATORY: St. Peters
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lingel Byers — ADDRESS: 5025 Pk Heights Ave

77087

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 640
50 0066

50 0066

BALTIMORE CITY HEALTH DEPARTMENT 151

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fannie Gardner Carroll

2. DATE OF DEATH: 1-2-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 651 W. Fairmount Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 651 W. Fairmount Ave 4-0

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 12, 1902
9. AGE (In years last birthday): 47
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Mt. Holly N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mack Carroll
ADDRESS: 651 W. Fairmount Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: Approx 18 mo

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug 1949.
19B. MAJOR FINDINGS OF OPERATION: Ca of Stomach. Int. obstruction
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1949, *to* Jan 1950, *that I last saw the deceased alive on* Jan 1, 1950, *and that death occurred at* 440 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Garland Shuiell M. D.
23B. ADDRESS: 902 W. Franklin
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: 1-5-1950
24C. NAME OF CEMETERY OR CREMATORY: MOUNT OLIVE CEM. Co
24D. LOCATION (City, town, or county) (State): CHARLOTTE N.C. N.C.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams
ADDRESS: 322 N. Schroeder St

JAN 4 1950 Huntington Williams

46B

PLEASE WRITE PLAINLY, WITH BINDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FOR BINDING

B400

50 0067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

761.5 50 0067

Registered No.

BIRTH NO. 50-00147

1. NAME OF DECEASED (Type or Print): Baby Girl Beal

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Maryland Gen. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp. Madison & Linden Sts.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07
D. STREET ADDRESS (If rural, give location): ~~Maryland General Hosp.~~ 1246 N. BROADWAY

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1/3/49 50
9. AGE (In years last birthday): If Under 1 Year — Months: Days: If Under 24 Hours — Hours: 12 Min.: 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Charles Beal
14. MOTHER'S MAIDEN NAME: Lena Mae Sturgill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Joseph Charles Beal — ADDRESS: 1246 N. Broadway Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature Birth

DUE TO

(B) Central Placenta Praevia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

hemorrage + shock in Mother.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3/50, 1950 *to* 1-4, 1950 *that I last saw the deceased alive on* 1-4, 1950 *and that death occurred at* 9:10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leslie A. Walker M. D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): B Removal
24B. DATE: Jan. 4 1950
24C. NAME OF CEMETERY OR CREMATORY: Norton Va.
24D. LOCATION (City, town, or county) (State): Norton Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William J. Tickner & Sons
ADDRESS: North & Pa. Aves

VS 150

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0068 50 0068

BIRTH NO. D 530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No.

1. NAME OF DECEASED (Type or Print): JOHN ARDIN DUNTY

2. DATE OF DEATH: Jan. 4th, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 10 N. Pulaski St.
C. Length of stay in Baltimore: 40 yrs. (40 Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 20-02
D. STREET ADDRESS (If rural, give location): 10 N. Pulaski St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 2nd, 1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months 4, Days 2; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Montgomery Ward & Co.
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Dunty
14. MOTHER'S MAIDEN NAME: Alice Carrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. John A. Dunty — ADDRESS: 10 N. Pulaski St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12/28/49

DUE TO

(B) Hypertensive Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/10/46 *19*__, *to* 1/4 *, 1950, that I last saw the deceased alive on* 1/4 *, 1950, and that death occurred at* 12:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph L. Laukaitis M. D.
23B. ADDRESS: 6 E Washington Blvd
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Lillington Williams, M.D.
25. FUNERAL DIRECTOR: Loudon Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

298 63 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0069

S-3 613

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0069

Registered No.

1. NAME OF DECEASED (Type or Print): Susan Stewart

2. DATE OF DEATH: January 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore (Yrs. Mos. Days): LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): 5709 Roland Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6-9-90
9. AGE (In years last birthday): 59
If Under 1 Year: Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Arthur Stewart
14. MOTHER'S MAIDEN NAME: Susan Ellicott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. 540.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subphrenic abscess & peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

DUE TO

(B) Leakage from esophago-duodenal anastomosis — 6 wks

DUE TO Peptic ulcer of stomach

(C) Total gastric resection — over 4 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10/26/49
19B. MAJOR FINDINGS OF OPERATION: Peptic ulcer, stomach
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12, 1949 *to* 1-3, 1950, *that I last saw the deceased alive on* 1-3, 1950, *and that death occurred at* 6 05 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Brown Jr. M. O.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: GREENMOUNT
24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR: 1-4-50
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: H.N. JENKINS & SONS CO.
ADDRESS: 4905 YORK RD.

VS 150

117a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37099

Letter in document file. 50-0069 - 3/31/50.

P-630

50 0070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

783 150 0070

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Albert Pratt

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 22 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 1106 E. Pratt St.

5. SEX: M.
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single?
8. DATE OF BIRTH: Oct. 19-1907
9. AGE (In years last birthday): 42
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None Laborer
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Pratt
14. MOTHER'S MAIDEN NAME: Nannie?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Patient. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemoptysis-Etiology undetermined — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

(B) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: not known

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1949 *to* 1-3, 1950, *that I last saw the deceased alive on* 1-3, 1950, *and that death occurred at* 12 33 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Margaret L. Howard M. D.
23B. ADDRESS: Mercy H
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN 6, 1950
24C. NAME OF CEMETERY OR CREMATORY: OWENS CEMETERY
24D. LOCATION (City, town, or county) (State): King George VA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: [illegible] M.D.
25. FUNERAL DIRECTOR: Thomas W. Singleton
ADDRESS: Glen Burnie Md.

VS ISO 98899

13B

V-522
50 0071

421.1

50 0071

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): EVELYNE VAN SICKLE

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: 5 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ~~1415 VESPER A~~ Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE Dundalk
D. STREET ADDRESS (If rural, give location): 1415 VESPER AVE.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 5/27/63
9. AGE (In years last birthday): 86 86 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: LEVI HAVEN
14. MOTHER'S MAIDEN NAME: ROSILLA SWINGLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: HOSPITAL RECORDS ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

(B) aortic insufficiency

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
R S Fisher
M.D.
CHIEF, BUREAU OF VITAL RECORDS

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fract of left femur, intertrochanteric 1 wk

19A. DATE OF OPERATION: 12/30/49
19B. MAJOR FINDINGS OF OPERATION: Fract of left hip
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1415 Vesper Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/28/49 A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell -- Slipped and fell to floor

22. *I hereby certify that I attended the deceased from* 12/28, 1949, *to* 1/4, 1950, *that I last saw the deceased alive on* 1/4, 1950, *and that death occurred at* 9 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul G. Herold M. D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10 ~~DECEMBER~~ JAN. 1950
24C. NAME OF CEMETERY OR CREMATORY: NEW METHODIST
24D. LOCATION (City, town, or county) (State): LAKE ARIEL, PENNA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Lawrence Williams, M.D.
25. FUNERAL DIRECTOR: Walter Brooke Bradley
ADDRESS: Dundalk

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-500

50 0072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 1

Registered No. 50 0072

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RALPH PAYNE

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 302 Birkwood Place
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 302 Birkwood Pl — Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 302 Birkwood Place

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: Nov 29-1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dorchester Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Payne
14. MOTHER'S MAIDEN NAME: Sarah E. Foxwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes. (If yes, give war or dates of service): World War I.
16. SOCIAL SECURITY NO.
17. INFORMANT: Alvin M Payne ADDRESS: 316 Radnor Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6-/50
24C. NAME OF CEMETERY OR CREMATORY: U. S. National
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: W T Cook Inc. ADDRESS: 1217 St Paul St

VS 151 27480 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-635

50 0073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-71.0 50 0073

Registered No.

BIRTH NO. 49-12220

1. NAME OF DECEASED (Type or Print) Brenda Mae Breeding

2. DATE OF DEATH 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ Hosp
C. Length of stay in Baltimore 7 ~~Yrs.~~ Mos. ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 8-06
D. STREET ADDRESS (If rural, give location) 1529 N. Div.

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 1949 6-6
9. AGE (In years last birthday) If Under 1 Year: Months 7, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Davis Breeding
14. MOTHER'S MAIDEN NAME Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Father ADDRESS Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acidosis
DUE TO
(B) Dehydration
DUE TO
(C) Diarrhea

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3, 1950, *to* 1-3, 1950, *that I last saw the deceased alive on* 1-3, 1950, *and that death occurred at* 9:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Edwin M. Hubbard M. D.
23B. ADDRESS Univ Hosp.
23C. DATE SIGNED 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/6/50
24C. NAME OF CEMETERY OR CREMATORY Prospect Hill
24D. LOCATION (City, town, or county) (State) Towson Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 5 - 1950
REGISTRAR'S SIGNATURE Lurington Williams M.D.
25. FUNERAL DIRECTOR William Cook
ADDRESS St Paul & Preston St

VS 150

119a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-455

50 0074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171

50 0074

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. ANNA CALMEN

2. DATE OF DEATH: January 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Bsltimore General Hosp
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 2708 Oakley Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 22, 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Isidore Fisher
14. MOTHER'S MAIDEN NAME: Dora Krome
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Benjamin Calmen
ADDRESS: 2708 Oakley Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix Uteri

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 18 *19* 49 *to* Jan. 4, *1950 that I last saw the deceased alive on* Jan. 4, *1950, and that death occurred at* 6 00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Silverstein M. D.
23B. ADDRESS: West Balto Gen. Hosp
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 5, 1950
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

48a

P-362

50 0075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

50 0075

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Mary Patterson

2. DATE OF DEATH: Jan 1, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 809 Somerset St.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 219 Dallas Ct. 6-05

5. SEX: F. 6. COLOR OR RACE: C. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: March 6, 1873 9. AGE (In years last birthday): 76 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md 12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: unknown 14. MOTHER'S MAIDEN NAME: Sarah Antone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): 16. SOCIAL SECURITY NO.:

17. INFORMANT: Gertrude Crofton ADDRESS: 809 Somerset

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pernicious Anemia — INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO

(B) Diabetes Mellitus — ?

DUE TO

(C) Hypertensive Cardio Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: 21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Dec 30, 1949 to Jan 1, 1950, that I last saw the deceased alive on Dec 31, 1949, and that death occurred at 8:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE: F. K. Adams M. D. 23B. ADDRESS: 222 N. Caroline 23C. DATE SIGNED: Jan 4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: Jan 5/50 24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem 24D. LOCATION (City, town, or county) (State): Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950 REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Robert G. Elliott ADDRESS:

61 Dauphin

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-130

50 0076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 31

Registered No. 50 0076

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JACOB LOVETT

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 65 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 2806 Norfolk Av.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 79 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Real Estate
10B. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eli
14. MOTHER'S MAIDEN NAME: Bessie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Annie Rovett — ADDRESS: 2806 Norfolk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

(B) cerebro-vascular accident

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) arterio-sclerosis

II
OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

diabetes

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3, 1950, *to* 1/4, 1950, *that I last saw the deceased alive on* 1/4, 1950, *and that death occurred at* 8 20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Krakower M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-50
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eutaw Pl

VS 150
27681

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-452

50 0077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

50 0077

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH Helen Williams

2. DATE OF DEATH: JANUARY 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1922 W. FRANKLIN ST
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-01
D. STREET ADDRESS (If rural, give location): 1922 W. Franklin St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: May 5, 1872
9. AGE (In years last birthday): about 77 yrs.
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Grice
14. MOTHER'S MAIDEN NAME: Geneva Hubbard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Spencer C. Williams
ADDRESS: 1922 W. Franklin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 hours
DUE TO with Right Hemiplegia
(B) Generalized Arteria sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* JAN. *, 1949, to* JAN 2 *, 1950, that I last saw the deceased alive on* JAN 2 *, 1950, and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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J-525

50 0078

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

00

50 0078

Registered No.

1. NAME OF DECEASED (Type or Print): Clarence Jenkins

2. DATE OF DEATH: Jan. 1-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 216 S. Sharp St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: 25 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 216 S. Sharp St
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 22-02
D. STREET ADDRESS (If rural, give location): 216 S. Sharp St

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1907
9. AGE (In years last birthday): 42 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY: Shirt Factory
11. BIRTHPLACE (State or foreign country): ~~Fla~~ South Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Benjamin F. Bryant — ADDRESS: 244 E. Poplar St York Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/17, 1949, *to* 1/1, 1950, *that I last saw the deceased alive on* 1/1, 1950, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dan Drawler M. D.
23B. ADDRESS: 112 W. Lee St
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan 6-49
24C. NAME OF CEMETERY OR CREMATORY: Branchville
24D. LOCATION (City, town, or county) (State): South Carolina

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James A. Hayes
ADDRESS: 638 N. Gilmor St

VS 150

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T-640

50 0079

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

Registered No. 50 0079

1. NAME OF DECEASED (Type or Print): Grace R. Tharle

2. DATE OF DEATH: Jan. 3/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1845 McHenry St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1845 McHenry St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 24, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Johnson
14. MOTHER'S MAIDEN NAME: Caroline -------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Peter W. Tharle, 1845 McHenry St.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, metastatic, Right Lung — INTERVAL BETWEEN ONSET AND DEATH: 3 years + unknown

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pernicious Anemia - Gall Stones

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14-46, 19__, *to* 1.4.50, 19__, *that I last saw the deceased alive on* Jan 3, 19 50, *and that death occurred at* 2 pm P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Raevin M. D.
23B. ADDRESS: 206 S. Gilmor St.
23C. DATE SIGNED: 1.4.50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry T. Wintze
ADDRESS: 4101 Edmondson Ave.

VS 150

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-436

50 0080

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 903.5

50 0080

Registered No.

1. NAME OF DECEASED (Type or Print): WEBSTER E. ALDER

N-852.0

2. DATE OF DEATH: January 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 607 S. Hanover Street

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Sept. 28-1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto Co Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Alder
14. MOTHER'S MAIDEN NAME: Frances Hale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Gertrude Jenkins
ADDRESS: ~~Street Ave~~ RFD-6-Towson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral concussion

DUE TO

ANTECEDENT CAUSES

(B) Acute alcoholism

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): York St. just west of Charles St. 22/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 3, 1950 11 p. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? fell to the street while drunk

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [X], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. Mc Clafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-50
24C. NAME OF CEMETERY OR CREMATORY: Mt Carmel
24D. LOCATION (City, town, or county) (State): Hereford Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J Luck
ADDRESS: 5305 Harford Rd

VS 151

000VV

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-152 ACC Room

0081

50 0081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benny Robinson

2. DATE OF DEATH: JAN 1 - 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto city

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 27 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 49 N. Dallas St

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 1, 96
9. AGE (In years last birthday): 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Sparrows Point
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? United

13. FATHER'S NAME: John Robinson
14. MOTHER'S MAIDEN NAME: Margaret Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of aneurysm of innominate artery into tracheo-bronchial tree - aneurysm wired 1947

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) tertiary syphilis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

peptic ulcer c previous resection

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City give street location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

NOT A MEDICAL EXAMINER'S CASE
DR. R. L. Frobes M.D.
CHIEF OR ASS'T. MEDICAL EXAMINER

22. I hereby certify that I attended the deceased from 1-1-1950, to 1-1-1950, that I last saw the deceased alive on 1-1-1950, and that death occurred at 6 15 m., from the causes and on the date stated above.

23A. SIGNATURE: Verne E. Chaney M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brunt

VS 150

988 4V To Be Approved by Medical Examiner 30 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

E-400

50 0082

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93172

50 0082

1. NAME OF DECEASED (Type or Print): EWELL, MOSES EDWARD

2. DATE OF DEATH: Jan 3, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — U S Marine Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U S Marine Hospital, Baltimore, 11, Md

C. Length of stay in Baltimore ?? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland,
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1026 Druid Hill Ave.

5. SEX: M
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec 8, 1885
9. AGE (In years last birthday): 64 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10B. KIND OF BUSINESS OR INDUSTRY: Hotel Waiter
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John O Ewell
14. MOTHER'S MAIDEN NAME: Alinda Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Records, US Marine Hospital, Baltimore, Md. ADDRESS: 11,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few hours

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Carcinoma of prostate with metastasis to vertebrae — Unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 7, 19 49 *to* Jan 3, 19 50, *that I last saw the deceased alive on* Jan 3, 19 50 *and that death occurred at* 1:27 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto. Md.
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

78087

51B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

H- 252

50 0083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0083

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Hawkins

2. DATE OF DEATH: JAN 4 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1404 Laurens St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 16, 1904
9. AGE (In years last birthday): 45
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph Jackson
14. MOTHER'S MAIDEN NAME: Elizabeth Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. 195X

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pituitary tumor, malignant — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.

DUE TO

(B) Respiratory failure — over 5 min.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1-3-, 1950, *to* 1-4-, 1950, *that I last saw the deceased alive on* 1-4, 1950, *and that death occurred at* 2:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert G. Freen M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sutleland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

55E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Letter in document file. 50-0083 3/8/50

S-530

50 0084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 1

Registered No. 50 0084

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALICE SMITH

2. DATE OF DEATH: January 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Jail
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 311 E. Lanvale Street

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: FEB. 10-1884
9. AGE (In years last birthday): 65 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS
10B. KIND OF BUSINESS OR INDUSTRY: MUDDY BLOUSE FACTORY
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: JAMES McNANEY
14. MOTHER'S MAIDEN NAME: JULIA WELSH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ALICE GERMERSHAUSEN — ADDRESS: 1239 BATTERY AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: A. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-6-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A.A.CO. MD

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elizabeth Harle Inc. — ADDRESS: 115 E. West St.

VS 151 434 06

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

M-610

50 0085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 1

50 0085 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Grace May Murphy

2. DATE OF DEATH: January 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 5103 Greenhill Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 2 1878
9. AGE (In years last birthday): 71 — If Under 1 Year: Months 3, Days 2; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward M. Hook
14. MOTHER'S MAIDEN NAME: Jane Armcast

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss Bernardine L. Schiers — ADDRESS: Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolism — due to Mural thrombus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Infarction due to Coronary arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/27/ *, 19* 49 *to* 1/4/ *, 19* 50 *that I last saw the deceased alive on* 1/4/ *, 19* 50 *, and that death occurred at* 7:00AM *., from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Haan M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 7, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State): Mt Carmel Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edgar W. Franklin
ADDRESS: 924 E. Eager St.

VS 150

94a

H-125

50 0086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E972.0

50 0086

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charlotte L. Hopkins N-968

2. DATE OF DEATH: Jan. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1435 Bolton St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 22, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: J. Seth Hopkins
14. MOTHER'S MAIDEN NAME: Charlotte S. Ludlow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Stockett M. Whiteley
ADDRESS: 3931 Canterbury Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon monoxide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1435 Bolton Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1-4-50 App. 11:00 A. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Three burners on stove on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R. S. Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 6, 1950
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Tunstington Williams M.D.
25. FUNERAL DIRECTOR: Stewart & Mowers Co.
ADDRESS: 108 W. North Ave. City #1 1632H

VS 151

LEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H-630

50 0087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.0

50 0087

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes R. P. Heyward

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. 44 Mos. Days Life.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-01
D. STREET ADDRESS (If rural, give location): 1001 Saint Paul Street

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.
8. DATE OF BIRTH: 26 June 1864
9. AGE (In years last birthday): 85
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H Perot
14. MOTHER'S MAIDEN NAME: Anna Heyerraft.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Self
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 12 Days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart disease

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31, 1949, *to* 1-4, 1950, *that I last saw the deceased alive on* 1-4, 1950, *and that death occurred at* 5:56 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Charles Grayhed M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 6/50
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Henry Hopkins & Sons
ADDRESS: 4905 York Rd

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

C-462

50 0088

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

023

Registered No. 50 0088

1. NAME OF DECEASED (Type or Print): ALEXANDER CLARK

2. DATE OF DEATH: January 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 536 Orchard Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April ? 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shucker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lucenie Ward ADDRESS 537 - Monroe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Syphilitic Aortitis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Aneurysm, popliteal, massive

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I [illegible] charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 3, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead - 918 Druid Hill Ave.
ADDRESS: 30D

VS 151

15660

S-660 50 0089 Shearer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0089

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barbara Shearer

2. DATE OF DEATH: Jan. 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission:)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1200 Valley St

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: July 23, 1863
9. AGE (In years last birthday): 86 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Huber
14. MOTHER'S MAIDEN NAME: Leona Stump
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sister Superior ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Edema Lungs — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Chronic Myocarditis — 5 yrs

DUE TO

(C) Arteio Sclerosis — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 20 *, 1949, to* Jan 4 *, 1950, that I last saw the deceased alive on* Jan 3 *, 1950, and that death occurred at* 3:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. Gill Hall M.D. M. D.
23B. ADDRESS: 1621 E. North Ave
23C. DATE SIGNED: Jan 5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 7, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld Goode Buddy
ADDRESS:

MVS 150

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937

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D-515

50 0090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0090
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Donovan

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: ? over 4 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 13-02
D. STREET ADDRESS (If rural, give location): 600 W North Avenue #17

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 9-13-1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lambertsville, N.J.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Peter Donovan
14. MOTHER'S MAIDEN NAME: Margaret Higgen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Bertha Bishop ADDRESS: 600 W North Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation - pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic (and or) Rheumatic heart disease — unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic lung disease etiology undetermined 20 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1950, *to* 1-4, 1950, *that I last saw the deceased alive on* 1-4, 1950, *and that death occurred at* 10 55 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louisa Candler M. D.
23B. ADDRESS: Md. general Hosp.
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. St. Marys Cem.
24D. LOCATION (City, town, or county) (State): Flushing, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1950
REGISTRAR'S SIGNATURE: Lucille Williams, M.D.
25. FUNERAL DIRECTOR: Chas F. Evans & Son Inc
ADDRESS: 93c 118 W. Mt. Royal Ave. Balto. Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly supplied.

M # 600
50 0091

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33 ✓

Registered No. 50 0091

1. NAME OF DECEASED (Type or Print): William F Murr

2. DATE OF DEATH: Jan 3 -1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 533 Patapsco Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY 533 Patapsco Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 25-04
D. STREET ADDRESS (If rural, give location): 533 Patapsco Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov II 1882 ?
9. AGE (In years last birthday): 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dep Srerrif
10B. KIND OF BUSINESS OR INDUSTRY: Sheriff Office
11. BIRTHPLACE (State or foreign country): Baltimore City
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Murr
14. MOTHER'S MAIDEN NAME: Anna Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: August Murr ADDRESS: 533 Patapsco Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Generalized Arteriosclerosis Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* Jan 3, 1950 *that I last saw the deceased alive on* Jan 3, 1950, *and that death occurred at* 1:45 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. E. Mendelson M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem
24D. LOCATION (City, town, or county) (State): Ritchie Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edward Toulson
ADDRESS: 2509 Wash Blvd Balto 30

VS 150
61298

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G-400

MS--134216

50 0092

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

007

50 0092

Registered No.

1. NAME OF DECEASED (Type or Print): John John Giel

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-23
D. STREET ADDRESS (If rural, give location): 939 Collington Ave. Zone 5 N.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 28, 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Patrol & Watchman Co.
11. BIRTHPLACE (State or foreign country): Maryland, Baltimore
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George Giel
14. MOTHER'S MAIDEN NAME: Barbara Gessner Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-3149
17. INFORMANT: Baltimore City Hospitals Records
ADDRESS: ~~4940 Eastern Ave.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14- *, 19*49*, to* 1-4- *, 19*50 *that I last saw the deceased alive on* 1-4- *, 19*50 *and that death occurred at* 2:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Chozen M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schlimmek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

MS 15

60283

13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 355

50 0093

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

50 0093

Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS P. GOODMAN

2. DATE OF DEATH: 1-5-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-03
D. STREET ADDRESS (If rural, give location): 1723 RUXTON AVE

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: FEB 26, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months: 10 Days: 9
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY: DEPT. STORE
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ISAAC GOODMAN
14. MOTHER'S MAIDEN NAME: RAY KOENIGSBURG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unkoown): UNKNOWN
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-6009
17. INFORMANT: SEYMOUR GOODMAN
ADDRESS: BALTIMORE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS — YEARS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4-50, 19__, *to* 1-5-50, 19__, *that I last saw the deceased alive on* 1-5, 19 50, *and that death occurred at* 7¹⁵ Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Charlton Shofed M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 6, 1950
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friend Ship
24D. LOCATION (City, town, or county) (State): Philadelphia Pa

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Carrington Williams, M.D.
25. FUNERAL DIRECTOR: David Sondheimer Son
ADDRESS: Catonsville 1902

VS 150

298 63

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

R 322

50 0094

50 0094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Radziszewski

2. DATE OF DEATH: Jan. 3-1950

3. PLACE OF DEATH: A. Baltimore City, Maryland City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Elmtree St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 25-05
D. STREET ADDRESS (If rural, give location): 1604 Elmtree St

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M.
8. DATE OF BIRTH: 1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Grabowski
14. MOTHER'S MAIDEN NAME: Josephine Foryszewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Radziszewski ADDRESS: 1604 Elmtree St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation with
DUE TO Pulmonary Edema

ANTECEDENT CAUSES

(B) Arterio-Sclerotic Cardio-
DUE TO Vascular Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Lubin M. D.
23B. ADDRESS: 320 Patapsco Ave
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 7-1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Kathryn Williams M.D.
25. FUNERAL DIRECTOR: Wm. B. Fialkowski ADDRESS: 2007 Eastern Ave

VS 150

JAN 5- 1950

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A 535

50 0095

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 50 0095

1. NAME OF DECEASED (Type or Print): MARY C. ANTHONY

2. DATE OF DEATH: Jan. 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2943 Clifton Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2943 Clifton Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan 9, 1884
9. AGE (In years last birthday): 65 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Timothy Cullen
14. MOTHER'S MAIDEN NAME: Bridget Donohue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Miss Catherine Anthony ADDRESS: 2943 Clifton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Auricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Myocarditis } Hypertension } → 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/4, 1948 *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel S. Shanahan M. D.
23B. ADDRESS: 1945 W. Balto. St.
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: St. Michael's Cem.
24D. LOCATION (City, town, or county) (State): Frostburg, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. PICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

H-155

50 0096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4201 1

Registered No. 50 0096

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM G. HOFFMAN

2. DATE OF DEATH: Jan. 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2319 W. Mosher St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 2319 W. Mosher St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 26, 1883
9. AGE (In years last birthday): 66 yrs.
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles A. Hoffman
14. MOTHER'S MAIDEN NAME: Mary E. McGinnis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Sadie B. Hoffman
ADDRESS: 2319 W. Mosher St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours

DUE TO

ANTECEDENT CAUSES

(B) Leg Amputation — 3 mos prior

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 2, 1950, *to* Jan 3, 1950, *that I last saw the deceased alive on* Jan 2, 1950, *and that death occurred at* 3 30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Elv Towns M. D.
23B. ADDRESS: 1202 St Paul St
23C. DATE SIGNED: Jan 6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.
24D. LOCATION (City, town, or county) (State): Randallstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-652

50 0097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175 Registered No. 50 0097

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Julia M. Francker

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 602 N. Loudon Ave

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
602 N. Loudon Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 16-08

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: May 24-1882
9. AGE (In years last birthday): 67 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Francis M. Richardson
14. MOTHER'S MAIDEN NAME: Eugenia Fonville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Adele Amsrud
ADDRESS: 602 N. Loudon Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of ovary with metastisis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO to the pelvis

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan., 1947 19__, *to* Jan. 4/50, 19__, *that I last saw the deceased alive on* 1-2-50, 19__, *and that death occurred at* 2:30P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Daniel S. Shawker M.D.
23B. ADDRESS: 1945 W. Baltimore St.
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas P. Towell
ADDRESS: 2427 Edmondson Ave

VS 150

49a

1945 W Bolt St

P-620 PRIESS

50 0098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

50 0098

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carrie Priess

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 115 N. Carey St

C. Length of stay in Baltimore: 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: 115 N Carey St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 115 18-02

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 6 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Schaffer
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Clementina Powell 115 N Carey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

ANTECEDENT CAUSES

(B) Chronic hypertension + — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Generalized Arterio-sclerosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 2, 1949, to Jan. 5, 1950, that I last saw the deceased alive on Jan. 5, 1950, and that death occurred at 11 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Frank N. Ogden M. D.
23B. ADDRESS: 2701 N. Calvert St.
23C. DATE SIGNED: Jan. 5, 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Rest
24B. DATE: Jan 7-1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 1950
REGISTRAR'S SIGNATURE: Lentington Williams, M.D.
25. FUNERAL DIRECTOR: Chas P. Towell
ADDRESS: 1301 Edmondson Ave

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly supplied.

H-453 50 0099 CERTIFICATE CORRECTED 50 0099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTHA HOLLAND — N-821.0

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: MD
B. COUNTY: FREDERICK
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CATONSVILLE
D. STREET ADDRESS (If rural, give location): 611a OLD FREDERICK RD.

5. SEX: F
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 4/15/72 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 78
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH HOPKINS
14. MOTHER'S MAIDEN NAME: MARY DELANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: IRMA HOPEWELL — ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS

DUE TO

(B) ARTERIOSCLEROTIC HEART — UNKNOWN

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) DISEASE & HYPERTENSION

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

FRACTURE OF SHAFT OF RT FEMUR — 1 DAYS

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION
CERTIFICATION APPROVED BY
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENT
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): BALTIMORE, MD
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/20/49 7:30 p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? FALL — Fell down stairsteps

22. I hereby certify that I attended the deceased from 12/27/49, to 1/5/50, that I last saw the deceased alive on 1/5/50, and that death occurred at 1:30 A.m., from the causes and on the date stated above.

23A. SIGNATURE OF ATTENDING PHYSICIAN: [illegible] M. D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-1950
24C. NAME OF CEMETERY OR CREMATORY: Fairview
24D. LOCATION (City, town, or county) (State): Frederick Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: [illegible] Williams M.D.
25. FUNERAL DIRECTOR: Mr Charles E. Rick III
ADDRESS: Frederick Md.

VS 150

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-6 50 50 0100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

50 0100

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Henry Brown

2. DATE OF DEATH: 4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission)
A. STATE: 25 E
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City, Md
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. COLOR OR RACE: W
7. (SINGLE) MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12-11-19
9. AGE (In years last birthday): 30
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Fisher Body Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wm. E. Brown
14. MOTHER'S MAIDEN NAME: Mary Gertrude O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary A. Van Meter
ADDRESS: Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebellar tumor
DUE TO with resultant herniation
(B) cerebral peduncle into
DUE TO foramen magnum
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

herniation

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 12-26-49, to Jan. 4, 1950, that I last saw the deceased alive on Jan. 4, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: Sherwood & Pratt
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 1/7/1950
24C. NAME OF CEMETERY OR CREMATORY: St. Thomas Cem.
24D. LOCATION (City, town, or county) (State): Harrison Forest, Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John Burns Sons
ADDRESS: Towson, Md.

JAN 5 - 1950
33639

87E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

25

50 0101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0101

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John. BERZIN.

2. DATE OF DEATH: JAN. 3 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore City.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1115 E. Pratt St.
C. Length of stay in Baltimore: 40. yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 3-02
D. STREET ADDRESS (If rural, give location): 1115. E. Pratt St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: Nov 21 1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper-on-truck
10B. KIND OF BUSINESS OR INDUSTRY: BARRELS
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? Russia

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Agnes. Berzin — ADDRESS: 1115. E. Pratt St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Arterular Fibrillation

DUE TO

(C) Cardio-vascular disease, arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31, 19 49 *to* Jan 3, 19 50, *that I last saw the deceased alive on* Jan 2, 19 50, *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Morris A. Fine M. D.
23B. ADDRESS: 110 Aisquith St
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Jan 5. 1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Trinity Cemetery
24D. LOCATION (City, town, or county) (State): Elkridge. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wendell J. Huppel
ADDRESS: 3125 Highland Ave

VS 150

988 10

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-160

50 0102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0102

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Milland Schaffer 158

2. DATE OF DEATH: January 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westminster
D. STREET ADDRESS (If rural, give location) Route #4

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 51 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LASTER
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant SHOE MFG.
11. BIRTHPLACE (State or foreign country): Carroll Co
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ernest Schaffer
14. MOTHER'S MAIDEN NAME: Margaret Null

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-05-1285
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — App. 10 mth
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-24-49
19B. MAJOR FINDINGS OF OPERATION: Carcinomatosis, Peritoneal
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-23, 1949 *to* 1-5, 1950, *that I last saw the deceased alive on* 1-5, 1950, *and that death occurred at* 7 30 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dwight C. McLean M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8/50
24C. NAME OF CEMETERY OR CREMATORY: Westminster Cem
24D. LOCATION (City, town, or county) (State): Carroll Co

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H Bankard Son Westminster Md.
ADDRESS

VS 150

49621

46M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

S-316

STOFFREGEN

50 0103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170

Registered No.

50 0103

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Stoffreger

2. DATE OF DEATH: January 4 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland 1-01
D. STREET ADDRESS (If rural, give location): 827 South Curley St. #12.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11-19-1907
9. AGE (In years last birthday): 42
If Under 1 Year: Months: 1 Days: 16
If Under 24 Hours: Hours: – Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cable Splicer
10B. KIND OF BUSINESS OR INDUSTRY: Gas + Electric Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William
14. MOTHER'S MAIDEN NAME: Eva Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 212-057-430
17. INFORMANT: MRS MARIE STOFFREGEN
ADDRESS: 827 S. Curley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Respiratory failure

DUE TO

(B) Carcinoma left Breast

DUE TO

(C) & Metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: June 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma - Left Breast
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/13, 1949, to 1/4, 1950, that I last saw the deceased alive on 1/4, 1950, and that death occurred at 8³⁰ P.m., from the causes and on the date stated above.

23A. SIGNATURE: Frank P. Dwyer Jr. M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9 1950
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem.
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E. Balto St. Balto. Md.

VS 150

45049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P-100

MS--130812

50 0104
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0 10

50 0104
Registered No.

1. NAME OF DECEASED (Type or Print): Neil Harrington Pope

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 1013 Whitelock St. Zone 17

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 18, 1943
9. AGE (In years last birthday): 6
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: Kindegarden
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Kent Pope
14. MOTHER'S MAIDEN NAME: Justine Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records--
ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous meningitis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-4- *, 19*49*, to* 1-4- *, 19*50*, that I last saw the deceased alive on* 1-4- *, 19*50*, and that death occurred at* 2:40P *m., from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Orzen M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Pk.
24D. LOCATION (City, town, or county) (State): Baltimore C. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520

50 0105

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

17°

Registered No. 50 0105

1. NAME OF DECEASED (Type or Print): MAUDE JONES

2. DATE OF DEATH: January 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: X
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1439 Mountmore Court

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 3, 1886
9. AGE (In years last birthday): 53 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Aaron Carter
14. MOTHER'S MAIDEN NAME: Mattie Coleman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Earl Jones — ADDRESS: 1612 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the breast — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. J. Pulaski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1631 Druid Hill Ave.

VS 151

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-340

MS--133224

50 0106

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20 1

Registered No. 50 0106

1. NAME OF DECEASED (Type or Print): Hudie Dudley

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days): 12 yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 1942 Loretta Ave.

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 14, 1915
9. AGE (In years last birthday): 34
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Skilled laborer
10B. KIND OF BUSINESS OR INDUSTRY: Steel Mill
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Salace Dudley
14. MOTHER'S MAIDEN NAME: Fanny Chapman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records--Baltimore City Hospitals
ADDRESS: ~~4940 Eastern Ave.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkin's Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 11-8-49
19B. MAJOR FINDINGS OF OPERATION: Lymph node biopsy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-5- *,* 1949 *, to* 1-4- *,* 1950 *, that I last saw the deceased alive on* 1-4- *,* 1950 *, and that death occurred at* 10:50AM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7, 1950
24C. NAME OF CEMETERY OR CREMATORY: ST. JOHN
24D. LOCATION (City, town, or county) (State): Caroline Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 0631 Druid Hill Ave.

VS 150

49629

44B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-520

50 0107

BIRTH NO. 4-95984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

325.5

50 0107

Registered No.

1. NAME OF DECEASED (Type or Print): Arnold Sylvan Reiness

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 209 S. Fremont Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 209 S. Fremont Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 21, 1947
9. AGE (In years last birthday): 2 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emanuel Reiness
14. MOTHER'S MAIDEN NAME: Evelyn Kaplan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Emanuel Reiness — ADDRESS: 209 S. Fremont Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tay-Sachs Disease — INTERVAL BETWEEN ONSET AND DEATH: congenital

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) congenital heart disease

DUE TO

(C) cerebral deterioration

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1947, *to* December, 1949, *that I last saw the deceased alive on* December 30, 1949, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter Mork M. D.
23B. ADDRESS: 1109 N. Calvert St
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Maryland Lodge, Rosedale
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros. — ADDRESS: 1124-26 N. North Ave.

VS 150

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F-6 52

50 0108

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157

Registered No. 50 0108

1. NAME OF DECEASED (Type or Print): May Franke

2. DATE OF DEATH: 1-3-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 40 Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Chas + 34th Sts
D. STREET ADDRESS (If rural, give location): Cambridge Arms Apartments

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 6, 1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher
10B. KIND OF BUSINESS OR INDUSTRY: Teaching
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gerhard F. Franke
14. MOTHER'S MAIDEN NAME: Laura W. Simmont

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Patient ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 15 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Biliary tract obstruction

19A. DATE OF OPERATION: August, 1949
19B. MAJOR FINDINGS OF OPERATION: mass at head of pancreas
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-16, 1948, *to* 1-3, 1950, *that I last saw the deceased alive on* 1-3, 1950, *and that death occurred at* 5 10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Cox 3rd M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Jan. 6, 1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Frd. Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John O. Mitchell Sons
ADDRESS: 1900 Eutaw Place

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-160
50 0109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

343

50 0109

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella A. Dewberry

2. DATE OF DEATH: 1-5-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1421 Winston Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: About 55
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator
10B. KIND OF BUSINESS OR INDUSTRY: Communication
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederick Dewberry
14. MOTHER'S MAIDEN NAME: Julia Dacey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sister FRANZ
ADDRESS: Mrs. Jos. Franz Northwood Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Encephalitis of Undetermined Etiology — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypostatic Pneumonia — 1 week

19A. DATE OF OPERATION: 12-15-49
19B. MAJOR FINDINGS OF OPERATION: Cortical Atrophy
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-6, 1949, to 1-5, 1950, that I last saw the deceased alive on 1-5, 1950, and that death occurred at 9:15 m., from the causes and on the date stated above.

23A. SIGNATURE: Margaret L. Shennard M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY ~~OR CREMATORY~~: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Timothy F. Williams M.D.
25. FUNERAL DIRECTOR: H. H. Mears and Son
ADDRESS: 805 N. Calvert St.

VS 150

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8012

G-100

50 0110

(3)

56.1

50 0110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Geppi (Geppe)

2. DATE OF DEATH: Jan 5-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4010 Colborne Rd
C. Length of stay in Baltimore: 53 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08
D. STREET ADDRESS (If rural, give location): 4010 Colborne Rd

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Feb 8-1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months 10, Days 27
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Cefalu, Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Di Crispino
14. MOTHER'S MAIDEN NAME: Maria-Anna Nota

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Geppi
ADDRESS: 4010 Colborne Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the liver — INTERVAL BETWEEN ONSET AND DEATH: 2 years.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 4, 1945, *to* Jan 5, 1950, *that I last saw the deceased alive on* Jan 4, 1950, *and that death occurred at* 3.55 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Geppe M. D.
23B. ADDRESS: 3101 W. Baltimore St.
23C. DATE SIGNED: Jan 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 9-1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Old Frederick Rd. Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph Lapice Inc.
ADDRESS: 2013 Greenmount Ave

VS 150

46 F

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

K-460

50 0111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 26

Registered No. 50 0111

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH KOEHLER

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 30 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-05
D. STREET ADDRESS (If rural, give location): 1606 Hazel St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 1920
9. AGE (In years last birthday): 30 — If Under 1 Year: Months -, Days -; If Under 24 Hours: Hours -, Min. -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathias Koehler
14. MOTHER'S MAIDEN NAME: Margaret Heidrich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: J.L.Wintering
ADDRESS: 1441 Woodall St. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial obstruction, mucus plug - during anesthesia.

DUE TO

ANTECEDENT CAUSES

(B) Bronchiectasis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-4-50
19B. MAJOR FINDINGS OF OPERATION: Bronchiectasis - Left lower lobe
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2, 1950 *to* 1-4, 1950 *that I last saw the deceased alive on* 1-4, 1950, *and that death occurred at* 11:40 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. J. Chenchaut Jr. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.
24D. LOCATION (City, town, or county) (State): Anne Arundel County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 403 S.Wolfe St. Balto.

VS 150

9065

106 B

W-200

50 0112

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0112

150

1. NAME OF DECEASED (Type or Print): Russell Louis Weiss

2. DATE OF DEATH: Jan. 1, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Balto., Md.
C. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Illinois
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chicago
D. STREET ADDRESS (If rural, give location): 3061 E. 91st Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb. 22, 1898
9. AGE (In years last birthday): 51
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wheelsman
10B. KIND OF BUSINESS OR INDUSTRY: Seafaring
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Victor Weiss
14. MOTHER'S MAIDEN NAME: Anna Bedour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 321 12 1716
17. INFORMANT: Records, US Marine Hospital, Balto., Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, squamous cell of esophagus with metastasis to trachea, left lung and liver — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pneumonia, bronchial, terminal — Few days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 4, 19 49 *to* Jan. 1, 19 50 *that I last saw the deceased alive on* Jan. 1, 19 50, *and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Medical Director M. D.
23B. ADDRESS: U. S. Marine Hospital, Balto., Md.
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 403 S. Wolfe St. Balto.

VS 150

46051

46a

H-532 50 0113 Ella Hentschel 50 0113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. No. 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella F. Hentschel

2. DATE OF DEATH: January 7 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2707 Southern Ave

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: 2707 Southern

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-02

D. STREET ADDRESS (If rural, give location): 2707 Southern Ave

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July 30 1884

9. AGE (In years last birthday): 65

If Under 1 Year: Months | Days

If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Herss

14. MOTHER'S MAIDEN NAME: Elizabeth Getz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Richard Hentschel ADDRESS: 2707 Southern

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO

(B) Coronary Occlusion Nov 30-49 to 1-3-50

DUE TO

(C) Hypertension — 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30th, 1949, to Jan 3rd, 1950, that I last saw the deceased alive on Jan 3rd, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE: R. R. Gordy M.D.

23B. ADDRESS: 5106 Harford Road

23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/50

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Parkville Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950

REGISTRAR'S SIGNATURE: Lurington Williams, M.D.

25. FUNERAL DIRECTOR: Albert Funeral Home

ADDRESS: 2908 Eliza St

VS 150

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650

50 0114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31

50 0114

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ARTHUR BROWN

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 250 N. PINE STREET
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 4-02
D. STREET ADDRESS (If rural, give location): 250 N. PINE STREET

5. SEX: MALE
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: SEPT 4, 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS BROWN
14. MOTHER'S MAIDEN NAME: FANNIE BRANFORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: SADIE BROWN
ADDRESS: 250 N. PINE ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: medium

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/20, 1949 *to* 1/4, 1950, *that I last saw the deceased alive on* 1/4, 1950 *and that death occurred at* 11:00 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Carmen M. D.
23B. ADDRESS: 753 Cerg St
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): BALTO.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. Jackson
ADDRESS: 916 Penna ave

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-420

50 0115

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17° Registered No. 50 0115

1. NAME OF DECEASED (Type or Print): Miss Elsie Roelkey Bayless

2. DATE OF DEATH: 1-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital
C. Length of stay in Baltimore: 59 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-05
D. STREET ADDRESS (If rural, give location): 712 Gorsuch Ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 11, 1890
9. AGE (In years last birthday): 59 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William T. Bayless
14. MOTHER'S MAIDEN NAME: Lillie M. Linthicum
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Bessie B. Webb — ADDRESS: 3022 Iona Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis +

DUE TO

(B) Generalized Metastatic carcinoma from

DUE TO

(C) Carcinoma of lt. Breast

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 31, 1949, *to* Jan. 4, 1950, *that I last saw the deceased alive on* Jan. 4, 1950, *and that death occurred at* 8:20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. C. Decker M. D.
23B. ADDRESS: Women's Hospital
23C. DATE SIGNED: 1-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-361

50 0116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150

50 0116

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HUGO A. STRIEBEL

2. DATE OF DEATH: January 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2226 E. North Avenue
C. Length of stay in Baltimore: 42 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-02
D. STREET ADDRESS (If rural, give location): 2226 E. North Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: August 4, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): brewery worker
10B. KIND OF BUSINESS OR INDUSTRY: American Brewery
11. BIRTHPLACE (State or foreign country): germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hans Striebel
14. MOTHER'S MAIDEN NAME: Amelia Heintzelmann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-01-4166B
17. INFORMANT: Mrs. Susanna Striebel ADDRESS: 2226 E. North Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Anaplastic carcinoma of esophagus — 6 mo

DUE TO

(C) Marked arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Biopsy 1949.
19B. MAJOR FINDINGS OF OPERATION: Anaplastic carcinoma of esophagus.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1949 *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 1 00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Conrad L. Rutter M. D.
23B. ADDRESS: 1706 N. Washington St
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Crematorium
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Lincoln Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150 496XO

46a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-514 50 0117

50 0117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary B. Kimball

2. DATE OF DEATH: January 3. 1950

3. PLACE OF DEATH A. Baltimore City, Maryland 1315 N. Washington St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07

D. STREET ADDRESS (If rural, give location): 1315 N. Washington St

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April-5-1859

9. AGE (In years last birthday): 90 yrs If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawson Applegarth

14. MOTHER'S MAIDEN NAME: Mary Merkimmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Harry Neuberger ADDRESS: 1315 N. Washington St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Marked arteriosclerosis — 15 yrs.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1949 *to* 1/3, 1950 *that I last saw the deceased alive on* Dec, 1949 *and that death occurred at* 9 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Conrad L. Rudy M.D. M. D.

23B. ADDRESS: 1706 N. Washington St

23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-6-50

24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.

24D. LOCATION (City, town, or county) (State): Northbro. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John F. Miller Inc.

ADDRESS: 2435 E. Oliver St

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be correct and legibly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Gaughey
1706 N. Washington St.

P-462

50 0118

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

50 0118

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Sarah Pillers

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 410 Orchard St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 410 Orchard St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 19, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Nathan Johnson
14. MOTHER'S MAIDEN NAME: ? Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Leo Pillers ADDRESS: 410 Orchard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Hemiplegia

DUE TO

(C) arteriosclerotic cardiovascular renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1949 *to* Jan 5, 1950, *that I last saw the deceased alive on* Jan 4, 1950 *and that death occurred at* 11:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: I. Abarofsky M. D. M. D.
23B. ADDRESS: 601 N. Monroe St
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley ADDRESS: 578 W. Biddle St.

0117

131a

B-650

50 0119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81

50 0119

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Henry Brown

2. DATE OF DEATH: 1/5/50 2:20 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2325 Harford Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 8-05
D. STREET ADDRESS (If rural, give location): 2325 Harford Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/5/1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Candy Maker
10B. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wesley Brown
14. MOTHER'S MAIDEN NAME: Cecilia Jane Barringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-18-7293
17. INFORMANT: Mr. Elizabeth Brown
ADDRESS: 2325 Harford Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer Bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 mo
DUE TO
Papilloma

ANTECEDENT CAUSES

(B)
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct 12-49
19B. MAJOR FINDINGS OF OPERATION: malig ment condition of bladder
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1949, to Dec 5, 1950, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE: John N Evans M. D.
23B. ADDRESS: 612 N 40 St.
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Winston Williams M.D.
25. FUNERAL DIRECTOR: Wm Bok Inc.
ADDRESS: 1217 St. Paul St.

VS 150
496X2

52 B

C-552

50 0120

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 445

Registered No. 50 0120

1. NAME OF DECEASED (Type or Print): LACY L. CUMMINGS

2. DATE OF DEATH: Jan. 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5535 Frederick Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-01A
D. STREET ADDRESS (If rural, give location): 5535 Frederick Ave.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 18, 1897
9. AGE (In years last birthday): 52 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Bartgis Bros.
11. BIRTHPLACE (State or foreign country): Jumping Branch, W. Va.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Wm. Cummings
14. MOTHER'S MAIDEN NAME: Martha McCormick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Grace L. Cummings ADDRESS: 5535 Frederick Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension, essential, severe — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

ANTECEDENT CAUSES

(B) Unknown —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic pulm. congestion; ascites — 3 months

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Feb, 1949, *to* Dec 5, 1949, *that I last saw the deceased alive on* Dec 5, 1949, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Stephen Lee Magness M. D.
23B. ADDRESS: Cumberland, Md
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Beaver Falls, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

356 12

102

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-500

50 0121

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0121
Registered No.

1. NAME OF DECEASED (Type or Print): PHILIP M. COHEN

2. DATE OF DEATH: 1-5-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write "Rural" and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2026 Linkton Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 65
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob
14. MOTHER'S MAIDEN NAME: Goldie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jerome B. Cohen
ADDRESS: 2026 Linkton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1945, 19__, *to* 1950, 19__, *that I last saw the deceased alive on* Jan 5, 1950, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3505 N. Charles St
23C. DATE SIGNED: Jan 6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-8-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young Men
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
23. FUNERAL DIRECTOR: Jack Kaufman Inc
ADDRESS: 2100 Eutaw Pl

VS 150 27681

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Albert Goldstein
3505 No Charles St
9 A M

B-623

50 0122

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 1 50 0122 Registered No.

1. NAME OF DECEASED (Type or Print): Jess Burkitt

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 25 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 1627 Ashburton St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 2nd. 1904
9. AGE (In years last birthday): 45
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY: Plastering
11. BIRTHPLACE (State or foreign country): West Virgina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Burkett
14. MOTHER'S MAIDEN NAME: Lena Camerom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unkoowo) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-18-0765
17. INFORMANT: Mrs. Annabell Burkett ADDRESS: 1627 Ashburton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9.50
24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. E. Beyer Jr.
ADDRESS: 1512 Hollins St.

VS 151

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-514

50 0123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33 r

50 0123

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT L. CAMPBELL

2. DATE OF DEATH JAN. 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2430 WOODBROOK AVE

C. Length of stay in Baltimore 22 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-09
D. STREET ADDRESS (If rural, give location) 2430 Woodbrook ave

5. SEX male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 1880

9. AGE (In years last birthday) 69 70 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener -

10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE

11. BIRTHPLACE (State or foreign country) Hedgeville Baltimore Co

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Dyaac Campbell

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Adelaide C. Smith ADDRESS 2430 Woodbrook ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan 1, 1950, *to* Jan 4, 1950, *that I last saw the deceased alive on* Jan 1, 1950, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE J. Douglas Sheppard M. D.

23B. ADDRESS 404 N. Fulton ave

23C. DATE SIGNED 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 9/49

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 6 - 1950

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR V. Brooks

ADDRESS 1463 N. Carey St

VS 150

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83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-620

50 0124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

155

50 0124

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hilda Crouse

2. DATE OF DEATH: Jan 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Balto.~~ Catonsville
D. STREET ADDRESS (If rural, give location): Box 211 Catonsville Md.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 9-4-02
9. AGE (In years last birthday): 47
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: Robert Keith
14. MOTHER'S MAIDEN NAME: Margaret Hood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Guy E. Crouse
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA GALL BLADDER

DUE TO

(B) C METASTASIS TO LIVER

DUE TO

(C) DIABETES MELLITUS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/12, 1949, *to* 1/6, 1950, *that I last saw the deceased alive on* 1/5, 1950, *and that death occurred at* 9:22 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Hunt M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/49
24C. NAME OF CEMETERY OR CREMATORY: St Marys
24D. LOCATION (City, town, or county) (State): Glyndon Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Paul E. Schmeisser Jr.
ADDRESS: 3645-12 Chestnut Ave

VS 150

46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-553

50 0125

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.3 50 0125

Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Mary G. Lamendola

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-03
D. STREET ADDRESS (If rural, give location): 1275 William Street

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: FeB. 23 1898
9. AGE (In years last birthday): 51 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwfe.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph SORTINO
14. MOTHER'S MAIDEN NAME: Josephine RAIMOND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MR. Thomas LAMEN DOLA — ADDRESS: 1275 William ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary edema
DUE TO cardiac decompensation

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/24/, 1949, *to* 1/5/, 1950, *that I last saw the deceased alive on* 1/5/, 1950, *and that death occurred at* 3:55 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Sowinski M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Entitled to Attested Copy
25. FUNERAL DIRECTOR: LEONARD J Ruck — ADDRESS: 5305 HARFORD

VS 150

95c

S-532

CERTIFICATE CORRECTED 1-13-1950

50 0126

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0126

Registered No.

1. NAME OF DECEASED (Type or Print): Adele Marie ~~Schmidt~~ Schmidtjohann

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): St. Joseph's
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 2852 Kentucky Ave.

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 28-1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailoress
10B. KIND OF BUSINESS OR INDUSTRY: Cohen & Goldman
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Phillip Schmidt Schmidtjohann
14. MOTHER'S MAIDEN NAME: ANNA MORMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. James Crockett ADDRESS: 1020 19th St. Wash. D.C.

MEDICAL CERTIFICATION

18. 195X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Post-Operative Shock — 12 hrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

19A. DATE OF OPERATION: Jan. 5, 1950
19B. MAJOR FINDINGS OF OPERATION: Pituitary Tumor, malignant
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 7, 1949, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 1950, *and that death occurred at* 1:10a *m., from the causes and on the date stated above.*

23A. SIGNATURE: James R. Allen M.D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6- 1950
REGISTRAR'S SIGNATURE: Lillington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford

VS 150

360 06

55E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Letter in document file. 50-0126 3/8/50.

B-425

50 0127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

401.3

50 0127

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Carl Blackmon

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 2 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02
D. STREET ADDRESS (If rural, give location): 920 W. North Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 28, 1928
9. AGE (In years last birthday): 21 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: SODA CLERK DRUG STORE
11. BIRTHPLACE (State or foreign country): Durham, North Carolina
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Lloyd Blackmon
14. MOTHER'S MAIDEN NAME: Cora Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Cora Blackmon
ADDRESS: 920 W. North Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Lung abscess, right

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/17/, 1949, *to* 1/6/, 1950 *that I last saw the deceased alive on* 1/6/, 1950, *and that death occurred at* 5:25 AM., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Swinski M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 1/6/50
24C. NAME OF CEMETERY OR CREMATORY: Durham
24D. LOCATION (City, town, or county) (State): Durham, North Carolina

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Cook, Inc.
ADDRESS: 1217 St. Paul Street

VS 150

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G200

50 0128

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0128

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH GEIS.

2. DATE OF DEATH: JAN. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3442 SECOND ST. (BROOKLYN)
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25-04
D. STREET ADDRESS (If rural, give location): 3442 SECOND ST.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: MAY 23, 1866
9. AGE (In years last birthday): 83
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): NEW YORK STATE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (First name unknown) BURGER
14. MOTHER'S MAIDEN NAME: unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ED. GEIS. ADDRESS: 3442 Second St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) arthritis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 20, 1949 *to* Jan 5, 1950 *that I last saw the deceased alive on* 1/4, 1950, *and that death occurred at* 3:10 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel Rubin M. D.
23B. ADDRESS: 203 Polakers ave
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial.
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): A. A. County - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Cuthrington Williams M.D.
25. FUNERAL DIRECTOR: S. Vernon Lemmon
ADDRESS: 4611 Pk. Hgts

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-5 16 50 0129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 50 0129 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA-BOICE-GAMBERTON.

2. DATE OF DEATH: January-6-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 120-S. London Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore 56 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-08
D. STREET ADDRESS (If rural, give location): 120-S. London Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May-22-1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stanton,- New Jersey.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Smith.
14. MOTHER'S MAIDEN NAME: Charlotte Waldron.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no.
(If yes, give war or dates of service): no.
16. SOCIAL SECURITY NO.: none.
17. INFORMANT: Mrs. Lydia Walsh,- 120 S. London Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

DUE TO

ANTECEDENT CAUSES

(B) Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1949, *to* Jan 6, 1950 *that I last saw the deceased alive on* Jan 5, 1950, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: J M Collins, M. D.
23B. ADDRESS: 3331 Frederick Ave
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9-1950
24C. NAME OF CEMETERY OR CREMATORY: London Park Cemetery.
24D. LOCATION (City, town, or county) (State): Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Charles J. Schwab - ADDRESS: 3512 Frederick Ave.

VS 150

830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-6 60 50 0130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

50 0130 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ellen Thrower

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1832 N. Caroline St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 9-09
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1832 N. Caroline St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 4, 1876
9. AGE (In years last birthday): 73
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Matthews County
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Brookie Ruff
14. MOTHER'S MAIDEN NAME: Lula Ruff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Brookie Johnson
ADDRESS: 1832 N. Caroline St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Jan. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 8/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Q A County Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Robert A. Elliott Daughter
ADDRESS: 1129 N. Carolina St

93D

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-12-0 50 0131

MS--129415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0131

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Willie Mae Davis

2. DATE OF DEATH: 1-5-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 718 N. Carrollton Ave.

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 15, 1924
9. AGE (In years last birthday): 25 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Willie Harris
14. MOTHER'S MAIDEN NAME: Delores Hazelton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records — ADDRESS: Baltimore City Hospitals ~~4940 Eastern Ave.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis of lungs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-4- *,* 1949 *, to* 1-5- *,* 1950 *that I last saw the deceased alive on* 1-5- *,* 1950 *, and that death occurred at* 6:40P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, ~~REMOVAL~~ (Specify):
24B. DATE: 1/8/50
24C. NAME OF CEMETERY OR CREMATORY: Chester Md.
24D. LOCATION (City, town, or county) (State): Queen Anne, Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leon B. Henry
ADDRESS: Easton Md.

VS 150

1313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-210

50 0132

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0132

1. NAME OF DECEASED (Type or Print): Donna Lee Wachob 571.0

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oliver Beach
D. STREET ADDRESS (If rural, give location): Middle River P.O. Balto Co Md

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 4/27/48
9. AGE (In years last birthday): 1 — If Under 1 Year: Months 9, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ✓
10B. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Clarence Wachob
14. MOTHER'S MAIDEN NAME: Nellie Schnyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓ (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Clarence Wachob — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Asphyxia due to

(A) Aspiration of vomitus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Acute gastroenteritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McCafferty, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery
24D. LOCATION (City, town, or county) (State): Balto Co

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Cunnington Williams, M.D.
25. FUNERAL DIRECTOR: James J. Brizdzinski
ADDRESS: 1407 Eastern Ave

1190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-300

50 0133

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

Registered No. 50 0133

1. NAME OF DECEASED (Type or Print): FRANCIS ATHEY

2. DATE OF DEATH: January 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 926 W. Baltimore Street
C. Length of stay in Baltimore: 11 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 926 W. Baltimore Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/30/1899
9. AGE (in years last birthday): 50
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Coverer
10B. KIND OF BUSINESS OR INDUSTRY: Reid-Hayden Co.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Athey
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): World War 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Catherine E Vance ADDRESS 926 W. Balto. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: New Balto. Nat'l. Cem.
24D. LOCATION (City, town, or county) (State): 5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 1950
REGISTRAR'S SIGNATURE: Huntington Hillegass, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 90 Hollins St.

VS 151 466 V9 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-523

BIRTH NO. 50 0134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0134

1. NAME OF DECEASED (Type or Print): JACOB CONSTANT

2. DATE OF DEATH: January 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Massachusetts
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Auburndale
D. STREET ADDRESS (If rural, give location): 9 Kingswood Road

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 30, 1903
9. AGE (In years last birthday): 46
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Branch manager
10B. KIND OF BUSINESS OR INDUSTRY: Roofing Co.
11. BIRTHPLACE (State or foreign country): Minneapolis, Minn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: A. Constant
14. MOTHER'S MAIDEN NAME: Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Carolyn Constant
ADDRESS: 9 Kingswood Road Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Boston Mass
24D. LOCATION (City, town, or county) (State): Boston Mass

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. F. Lamoreau
ADDRESS: 4516 Liberty Hgts Ave

VS 151

156 V9

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be entered if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-462

50 0135
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

260

50 0135
Registered No.

1. NAME OF DECEASED (Type or Print): MARY CLARK

2. DATE OF DEATH: January 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: 10 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 300 E. 30th Street

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/4/1894
9. AGE (In years last birthday): 55 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Burkeville Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Hughes Fisher
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Sallie Elliott — ADDRESS: 300 E 30th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coma — acidosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO diabetes mellitus — Unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: B B Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/8/50
24C. NAME OF CEMETERY OR CREMATORY: Calvary Baptist
24D. LOCATION (City, town, or county) (State): Burkeville Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. Harper — ADDRESS: 512 Fairview Av.

VS 151

52086

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-244

CERTIFICATE CORRECTED 1-10-1950

BIRTH NO. 50 0136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

Registered No. 50 0136

1. NAME OF DECEASED (Type or Print): Mary Matilda McClelland

2. DATE OF DEATH: Jan - 5 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Nursing Home 212 Stony Run Lane Balto
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): New Howard Hotel 8 N. Howard St Balto - 1 - Md

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May - 22 - 1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Mississippi St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Saul Pagson
14. MOTHER'S MAIDEN NAME: Jane Welsh Welsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Freda Erdman — ADDRESS: 1412 Park Ave
Mr. George A. Scharf — 8 N. Howard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: ? 2 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Lung, Left — ? 6 mos

DUE TO

(C) Generalized Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec - 17 - 1949, *to* Jan - 5 - 1950, *that I last saw the deceased alive on* Jan - 3 - 1950, *and that death occurred at* 7 *a.m./p.m., from the causes and on the date stated above.*

23A. SIGNATURE: George Y. Johnson M. D.
23B. ADDRESS: 20 E. Preston St Balto (2)
23C. DATE SIGNED: 1 - 6 - 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Son.
ADDRESS: Balto. 17, Md.

VS 150

73287

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-653
50 0137

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0137

1. NAME OF DECEASED (Type or Print): Frank C. Behrendt

2. DATE OF DEATH: Jan 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3813 Birchview Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-05
D. STREET ADDRESS, (If rural, give location): 3813 Birchview Ave

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 11, 1868
9. AGE (In years last birthday): 81
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: CAN MFG.
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Behrendt
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Louis Behrendt ADDRESS: 3900 Pinewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY ARTERY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROTIC HEART DISEASE — 2 yrs +

DUE TO

(C) CORONARY ARTERIOSCLEROSIS — 2 yrs +

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

SENILITY

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1949, to 1/5, 1950, that I last saw the deceased alive on 1/5, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE: John W Machen M. D.
23B. ADDRESS: 6331 Belair Rd (6)
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood.
24D. LOCATION (City, town, or county) (State): Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Michael T. Bright
ADDRESS: 6009 Harford Rd.

VS 150
3263V
93D

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6331 Belair Rd.

2 to 4

F-620

50 0138

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

784.5

Registered No. 50 0138

1. NAME OF DECEASED (Type or Print): Mary E. Frush 785.6 ?

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Garden Apts.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 12-2
D. STREET ADDRESS (If rural, give location): 3001 N. Charles St. Homewood Apts.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: April 15, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry S. Frush
14. MOTHER'S MAIDEN NAME: Hannah W. Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Harry S. Dickey
ADDRESS: 21 Arbutus Ave. Catonsvil

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs
DUE TO
(B) Diarrhea of unknown origin — 17 hrs
DUE TO
(C)

See of Hemorrhage just prior to death

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 4/5/49, 19__, *to* 1/5/50, 19__, *that I last saw the deceased alive on* 1/4/50, 19__, *and that death occurred at* 9:30 AM *from the causes and on the date stated above.*

23A. SIGNATURE: Francis W. Gluck M. D.
23B. ADDRESS: 3406 St. Paul St.
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John D. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

VS 150

120 B

S-455

50 0139

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0139

1. NAME OF DECEASED (Type or Print): James Homer Slemons

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~644 Gorsuch Ave.~~
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Beth. Diagnostic Clinic UX 100 23 & Sec Baltimore
C. Length of stay in Baltimore: 29 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 9-05
D. STREET ADDRESS (If rural, give location): 644 Gorsuch Ave.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 27, 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.
11. BIRTHPLACE (State or foreign country): Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Slemons
14. MOTHER'S MAIDEN NAME: Ann M. Barwick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary H. Slemons
ADDRESS: 644 Gorsuch Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — 2 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1949, *to* Jan 5, 1950, *that I last saw the deceased alive on* Jan 5, 1950, *and that death occurred at* 1630 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hardey Beck M. D.
23B. ADDRESS: 2301 St. Paul St.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
24D. LOCATION (City, town, or county) (State): Salisbury, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell Sons
ADDRESS: 1900 Eutaw Place

VS 150

26629

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-530

50 0140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

401.1

50 0140

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERT M. LAMOTTE

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. State: Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

C. Length of stay in Baltimore: 41 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 9-07
D. STREET ADDRESS (If rural, give location): 2536 GARRETT AVE.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: SEPT 3, 1908

9. AGE (In years last birthday): 41

If Under 1 Year: Months | Days

If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS C. LAMOTTE

14. MOTHER'S MAIDEN NAME: CECELIA MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. MILDRED LAMOTTE

ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RHEUMATIC HEART DISEASE (MITRAL STENOSIS) — INTERVAL BETWEEN ONSET AND DEATH: 8 YEARS

DUE TO

(B) RHEUMATIC FEVER — 23 YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. multiple pulmonary emboli

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/27, 1949, *to* 1/6/, 1950, *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 7^35 *Am., from the causes and on the date stated above.*

23A. SIGNATURE: M. F. Cox M. D.

23B. ADDRESS: Union Memorial Hospital

23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 9/1950

24C. NAME OF CEMETERY OR CREMATORY: St Joseph's

24D. LOCATION (City, town, or county) (State): Hanover Pa

DATE RECEIVED BY LOCAL REGISTRAR: 6-1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Edw. C. Tipton

ADDRESS: Hampstead Md

VS 150

92 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

E-430

BIRTH NO. 50 0141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0141

1. NAME OF DECEASED (Type or Print): Bertha E. Elliott

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2117 St. Paul St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 12-04
D. STREET ADDRESS (If rural, give location): 2117 St. Paul St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 8/15/1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months 4 Days 20 Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): N. J.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Geo. W. Reynolds
14. MOTHER'S MAIDEN NAME: Ella M. Eldridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mabel R. Leary
ADDRESS: 2117 St. Paul St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: O. K. Rao
ADDRESS: 1217 St. Paul St.

VS 151

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given or supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-263

50 0142
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56.1

50 0142
Registered No.

1. NAME OF DECEASED (Type or Print): Charles L. Swigert
2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 3108 Walbrook Ave

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2-8-1876
9. AGE (In years last birthday): 73
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Swigert
14. MOTHER'S MAIDEN NAME: Jane Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of liver
~~DUE TO~~
(B) haemic cirrhosis
~~DUE TO~~
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/9, 1949 *to* 1/6, 1950 *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 1:05 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Edgar H. Schaeurich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. — ADDRESS: 1217 St Paul St

VS 150

L1098

46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-616

143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 8 1 2. 4

Registered No. 50 0143

1. NAME OF DECEASED (Print): Elizabeth Driver N-803.2

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-05
D. STREET ADDRESS (If rural, give location): 425 Hornel St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 6 1887
9. AGE (In years last birthday): 63
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Hungaria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Danial Driver
ADDRESS: 425 Hornel St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed Skull

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public (road)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Guslian Ave. & Dundalk Ave., Balto.Co.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1-5-50 10:40 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ped. struck by auto.

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8/50
24C. NAME OF CEMETERY OR CREMATORY: Oakdawn
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
28. FUNERAL DIRECTOR: Fred W. Ozazewski
ADDRESS: 1960 Eastern Ave.

170 c

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-651

BIRTH NO. 50 0144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0144

1. NAME OF DECEASED (Type or Print): Vivian Turnipseed

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 1006 Briscoe St.

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: ?
9. AGE (in years last birthday): 45
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gainesville Georgia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Burl Sanford
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Sanford
ADDRESS: 1006 Briscoe Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* [illegible] *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
Autopsy, Inspection or Inquiry

23A. SIGNATURE: Earl L. Kruger M.D.
23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 2, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Interrator Williams, Jr.
25. FUNERAL DIRECTOR: L. L. Brown & Son
ADDRESS: Montgomery

VS 151 77087 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if information is available or supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-100

50 0145

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 11

50 0145

Registered No.

1. NAME OF DECEASED (Type or Print): HARRY FORREST SWOPE, SR.

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-11
D. STREET ADDRESS (If rural, give location): 20 Whitfield Avenue, Balt.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 15, 1875
9. AGE (In years last birthday): 74 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired - Banking
10B. KIND OF BUSINESS OR INDUSTRY: Clef. Brown & Sons
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Granville H. Swope
14. MOTHER'S MAIDEN NAME: Emma Buckingham ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: U.M.H. records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

ANTECEDENT CAUSES

(B) Result — Rheumatic heart

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Disease of aortic valve & mitral insufficiency

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29-49, 19__, *to* 1-6-50, 19__, *that I last saw the deceased alive on* 1-6-50, 19__, *and that death occurred at* 11 55 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marshall T. Carrier, M.D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 9 '50
24C. NAME OF CEMETERY OR CREMATORY: Orchid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Henry N. Jenkins & Sons Co.
ADDRESS: 4925 York Rd.

VS 150

1568V

92 c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given or supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A 140

50 0146
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0146

1. NAME OF DECEASED (Type or Print): William J.F. Appel

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 3233 Fait Ave.

5. SEX: M
6. COLOR OR RACE: W M
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): m
8. DATE OF BIRTH: Oct. 23, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Leak Finder
10B. KIND OF BUSINESS OR INDUSTRY: Paul Jones Dist.
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob.
14. MOTHER'S MAIDEN NAME: Katherine Busz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Kate W. Appel
ADDRESS: 3233 Fait Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): 7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 1950
REGISTRAR'S SIGNATURE: Lawrence Williams M.D.
25. FUNERAL DIRECTOR: Clarence F. Hoffmann
ADDRESS: 1639 Broadway.

VS 151 336 XO

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-600
50 0147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

541.0 50 0147
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Laurence E. Burrs
2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 709 W. Hamburg St.
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 709 W. Hamburg St.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/13/1901
9. AGE (In years last birthday): 48 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10B. KIND OF BUSINESS OR INDUSTRY: Gov. Low Glass Co.
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?: U S A
13. FATHER'S NAME: Joseph F. Burrs
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Irene L. Burrs
ADDRESS: 709 W. Hamburg St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSES

(B) Duodenal Ulcer — 6 mos.

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Psychasthenia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Psychasthenia — 6 mos.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4, 1949, *to* 1-6, 1950, *that I last saw the deceased alive on* 12-31, 1949, *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John P. Ulrich, Jr. M. D.
23B. ADDRESS: 1227 Wash. Blvd
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem.
24D. LOCATION (City, town, or county) (State): 2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 1170 Hollins St.

VS 150 496.25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be c[illegible]lly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and lo[illegible]

A-416

50 0148
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4r0'0

50 0148
Registered No.

1. NAME OF DECEASED (Type or Print): HENRY ALBERT

2. DATE OF DEATH: Jan. 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5310 Park Heights Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5310 Park Heights Ave.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 26, 1877
9. AGE (In years last birthday): 72 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY: Heating
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Albert
14. MOTHER'S MAIDEN NAME: Kunigunda Fisher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Lisetta Albert
ADDRESS: 5310 Park Heights Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arterio Sclerosis — 5 yrs.

DUE TO

(C) Chronic Nephritis — 5 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile dementia — 2 yrs.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 10, 1945, *to* Jan. 4, 1950, *that I last saw the deceased alive on* Jan. 4, 1950, *and that death occurred at* 9.10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts Ave.
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Lillington Williams, Mgr.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

15630

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-420 For approval of Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 900.0

BIRTH NO. 50 0149 — Registered No. 50 0149

1. NAME OF DECEASED (Type or Print): MARGARET NEDDO PYLES — N-854.0

2. DATE OF DEATH: JAN. 6. 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. — 12-05
D. STREET ADDRESS (If rural, give location): 1706 Guilford Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married (separated)
8. DATE OF BIRTH: Nov. 25, 1868
9. AGE (In years last birthday): 81 yrs. — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: - Hogan
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Leo Neddo, son — ADDRESS: 1706 Guilford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural Hemorrhage Retroperitoneal + Retroplacental Hemorrhage — 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis, advanced

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY for Dr. Wm. Helgrich
By: B. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1706 Guilford Ave 12/5
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1-4-50 9 A. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Fell down cellar steps

22. *I hereby certify that I attended the deceased from* Jan. 5, 1950, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 1950, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Stephen K. Padmis M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Christington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

G- 432

50 0150

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171

Registered No. 50 0150

1. NAME OF DECEASED (Type or Print): Edna M. Goldstraw

2. DATE OF DEATH: Fri Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1636 S. Charles St.
C. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1636 S. Charles St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 5, 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home —
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Snell
14. MOTHER'S MAIDEN NAME: Adeline Homer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Wm. T. Goldstraw (Husband) ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
Metastatic Carcinoma of Lungs — 2 mos

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Metastatic Brain Ca

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 19 37 to January 6, 19 37, that I last saw the deceased alive on Jan 5, 1950, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Isaac Muller M.D. M. D.
23B. ADDRESS: 1224 S Charles St
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Monday 9 1950
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): G. A. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Evans
ADDRESS: 1400 S. Charles St Balto 30, Md.

VS 150

48a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620

50 0151
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H20 . 1 50 0151
Registered No.

1. NAME OF DECEASED (Type or Print): Miss Madelaine May Gregg

2. DATE OF DEATH: January 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3232 Abell Avenue
C. Length of stay in Baltimore: 35 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 3232 Abell Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse Registered
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William F. Gregg
14. MOTHER'S MAIDEN NAME: Matilda Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ---
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: W. F. Gregg, Jr.
ADDRESS: 758 Village Ave., York, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion
DUE TO
(B) Arteriosclerosis yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R B Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/6, 19[illegible] *to* 1/6, 1950, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Green Mount Crematory
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

Vs 150
V3692
94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

K+ 520 B.C. 50-no 652

50 0152
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

774 Registered No. 50 0152

1. NAME OF DECEASED (Type or Print): Baby Girl King

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital 43
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): 1811 Jackson Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1/3/50
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 3 | If Under 24 Hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert R. King
14. MOTHER'S MAIDEN NAME: Esther Blum
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Labor Premature
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3/50, 19__, *to* 1/6/50, 19__, *that I last saw the deceased alive on* 1/6/50, 19__, *and that death occurred at* 1:35 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. K. Hollister M. D.
23B. ADDRESS: 1213 Light St. Baltimore, Md.
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 1-7-50
24C. NAME OF CEMETERY OR CREMATORY: Friendship
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James B. McCauley
ADDRESS: 130 S. Fort Ave.

VS 150

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-615

Dr. Ralph Young

50 0153
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 903.0

Registered No. 50 0153

1. NAME OF DECEASED (Type or Print): HANNAH JANE PURVIANCE

N-927.0

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1209 Druid Hill Ave.
C. Length of stay in Baltimore: 90 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
11-04
D. STREET ADDRESS (If rural, give location): 1209 Druid Hill Ave.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 17, 1860
9. AGE (In years last birthday): 90 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Johnson
14. MOTHER'S MAIDEN NAME: Hannah J. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Florence Purviance
ADDRESS: 1209 Druid Hill Ave ✓

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — Interval between onset and death: Jan 3, 1950

DUE TO

ANTECEDENT CAUSES

(B) due to bed confinement — Dec 15-to Jan 5/50

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) due to fall and injuring hip (Rt) (wrenched hip + knee Rt) (sprained knee and contused hip) — Dec 15, 1949

fracture? or sprain? abrasion? contusion?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cardio-Renal disease and general senile debilitation

19A. DATE OF OPERATION: No
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): At home 1209 Druid Hill Ave 11/4
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 15, 1949 34 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? going during night wandering around room and fell in floor.

22. I hereby certify that I attended the deceased from Dec 15, 1949 to Jan 5, 1950, that I last saw the deceased alive on Jan 5, 1950, and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE: Ralph J Young M. D.
23B. ADDRESS: 1424 E Monument St
23C. DATE SIGNED: Jan 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D-520

Dr. Harman

BIRTH NO. 50 0154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150

Registered No. 50 0154

1. NAME OF DECEASED (Type or Print): WILLIAM L. DENNIS

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2101½ McCulloh Street
C. Length of stay in Baltimore: 72 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 2101½ McCulloh Street

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 18, 1877
9. AGE (In years last birthday): 72 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10B. KIND OF BUSINESS OR INDUSTRY: Private club
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Dennis
14. MOTHER'S MAIDEN NAME: Mary Golder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Grace A. Dennis — ADDRESS: 2101½ McCulloh Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) .....
DUE TO
(B) .....
DUE TO
(C) .....

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE — M. D.
23B. ADDRESS
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 8, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Winfrey for Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1631 Druid Hill Ave.

VS 150

780 94

0153

46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-650

BIRTH NO. 50 0155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0155

1. NAME OF DECEASED (Type or Print): JOHN WESLEY BROWN

2. DATE OF DEATH: January 3, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 1620 Pierce Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: April 5, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John W. Brown
14. MOTHER'S MAIDEN NAME: Henrietta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Paul Mitchell
ADDRESS: 1620 Pierce Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V. Disease

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L. Kaye M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Pennington Williams, M.D.
25. FUNERAL DIRECTOR: Mr Katie R. Williams
ADDRESS: 322 N Schroeder St

VS 151

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-630

BIRTH NO. 50 0156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

587.0

Registered No. 50 0156

1. NAME OF DECEASED (Type or Print): Eva Howard

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 703 W. Lexington St.

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Nov. 17, 1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Maryland
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: James Williams
14. MOTHER'S MAIDEN NAME: Josephine Bell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ——
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.:
17. INFORMANT: Josephine Morsell
ADDRESS: 69 W. 130 St. N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute hemorrhagic pancreatitis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

Autopsy, Inspection or Inquiry

23A. SIGNATURE: Earl L. Kaye M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 3, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams
ADDRESS: 322 N. Schroeder St.

VS 151

128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-620

50 0157

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 002

50 0157

Registered No.

1. NAME OF DECEASED (Type or Print): John Moroz (JOHN NORMAN MOROZ)

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Essex (over)
D. STREET ADDRESS (If rural, give location): Endowood Ave.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 5-18-30
9. AGE (In years last birthday): 19
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN N. MOROZ
14. MOTHER'S MAIDEN NAME: Mamie Moroz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Operation for

DUE TO

(B) Pulmonary Tuberculosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
B B Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 1/6/50
19B. MAJOR FINDINGS OF OPERATION: Pulmonary tuberculosis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/22, 1949, *to* 1/6, 1950, *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 1:00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas N P Johns M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Christ Evangelical Church Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: Baltimore - 13, Md.

VS 150

Medical Case Released to Hospital 13B to be approved

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

By phone 1/9/50 - ES

From Sanders & Sons, Funeral Directors

Box # 405 - Rt 13

Back River Neck Rd

Essex, Balto County, Md

L-563

50 0158

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.0

50 0158

Registered No.

1. NAME OF DECEASED (Type or Print): LOUISE ANNA LIMROTH

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1844 Harford Avenue
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1844 Harford Avenue

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 8, 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant
10B. KIND OF BUSINESS OR INDUSTRY: Limroth's Rest.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick W. Limroth
14. MOTHER'S MAIDEN NAME: Anna Knoepp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 1844 Harford Avenue - 13 Mrs. Helen M. Cleaver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

(B) Arteriosclerotic Heart Disease — ?

DUE TO

(C) Diabetes Mellitus — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 47, 19__, *to* Jan 5, 1950, *that I last saw the deceased alive on* Jan 5, 1950, *and that death occurred at* 3:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Roy W. Zimmerman M. D.
23B. ADDRESS: 2858 Harford Rd
23C. DATE SIGNED: 6 Jan. 50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

15671

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-532

BIRTH NO. 50 0159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

241

Registered No. 50 0159

1. NAME OF DECEASED (Type or Print): Mrs. Alice J. Santas

2. DATE OF DEATH: Jan. 5, 1950.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 868 W. Fayette St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ----
00
c. Length of stay in Baltimore 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Maryland
B. COUNTY: --
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 868 W. Faytte St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 20, 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months ---- Days ----
If Under 24 Hours: Hours ---- Min. ----

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Felling Hand
10B. KIND OF BUSINESS OR INDUSTRY: Tailoring
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ----
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 217-03-8234
17. INFORMANT: Mrs. Mary Ingson ADDRESS: 939 W. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

(B) Bronchial Asthma — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1947 *to* Jan 5, 1950, *that I last saw the deceased alive on* Jan 5, 1950, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Mendelis M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Lennington Williams, M.D.
25. FUNERAL DIRECTOR: Charles W. Fackenthal
ADDRESS: 703 McHenry St

VS 150

112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

462 JR LEGUM

50 0160
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170

Registered No. 50 0160

1. NAME OF DECEASED (Type or Print): CECIL D. SALYERS

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2510 Maryland Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-7
D. STREET ADDRESS (If rural, give location): 2510 Maryland Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 25, 1903
9. AGE (in years last birthday): 46 — If Under 1 Year: Months 6, Days 11; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10B. KIND OF BUSINESS OR INDUSTRY: Sears, Roebuck & Co
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jerry Caudle
14. MOTHER'S MAIDEN NAME: Margaret Connelly
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: William H. Salyers — ADDRESS: 2510 Maryland Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma left Breast — INTERVAL BETWEEN ONSET AND DEATH: a few months
DUE TO
(B) Generalized Carcinomatosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1944 *to* Jan 6, 1950 *that I last saw the deceased alive on* Jan 6 1950 *and that death occurred at* 8:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 1761 E North Ave
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan. 7, 1950
24C. NAME OF CEMETERY OR CREMATORY: Hunnewell Cemetery
24D. LOCATION (City, town, or county) (State): Greenup, Kentucky

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Good, Inc. — ADDRESS: 1217 St. Paul Street

VS 150

29863

50

M-244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0161 491 Registered No. 50 0161

1. NAME OF DECEASED (Type or Print): John H. McClellan

2. DATE OF DEATH: Jan. 2, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) 18-02
D. STREET ADDRESS (If rural, give location) 1047 W. Lexington St.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: II/2I/I909
9. AGE (In years last birthday): 40 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: In Gen.
11. BIRTHPLACE (State or foreign country): Marion North Carolimia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Henry McClellan
14. MOTHER'S MAIDEN NAME: Pearl Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Pearl Robinson — ADDRESS: Marion N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronco-Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Jan. 3, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: I/7/I950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 7 - 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Ave.

VS 151

98899 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-550
50 0162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Hro.1 50 0162
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isaiah Bowman
2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 13 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 3908 N. Charles St.

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-26-78
9. AGE (In years last birthday): 71
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired President
10B. KIND OF BUSINESS OR INDUSTRY: John Hopkins University
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Bowman
14. MOTHER'S MAIDEN NAME: Emily Schantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 6, 1950, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 1950, *and that death occurred at* 8 20 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph D. B. King M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1-8-50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Lillington Williams M.D.
25. FUNERAL DIRECTOR: John O. Mitchell
ADDRESS: Hons 1900 Eutaw Pl.

VS 150

V1091

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-145

50 0163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

204.3 50

Registered No. 0163

BIRTH NO. Wade L.

1. NAME OF DECEASED (Type or Print): Wade Chaplin

2. DATE OF DEATH: JAN 6 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 1 Mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE S. Carolina
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Neeses
D. STREET ADDRESS (If rural, give location)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 2-25-48
9. AGE (In years last birthday): 1 — If Under 1 Year: Months 10, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): S. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harold Chaplin
14. MOTHER'S MAIDEN NAME: Virginia Livingston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) .....
DUE TO
ANTECEDENT CAUSES
(B) .....
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Acute leukemia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1- *,* 19 49 *, to* 1-6- *,* 19 50 *, that I last saw the deceased alive on* 1-6 *,* 19 50 *, and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harriet G. Guild M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jany 9/50
24C. NAME OF CEMETERY OR CREMATORY: Neesis Cemetery
24D. LOCATION (City, town, or county) (State): Neesis, S. C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1950
REGISTRAR'S SIGNATURE: Lennington Williams M.D.
25. FUNERAL DIRECTOR: John D. Mitchell Sons
ADDRESS: 1904 Eutaw Place

JAN 8 1950

74a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be ... correct age is especially important. Physicians: please write the causes of death clearly and ...

E-164

50 0164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57°.5 50 0164

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EBERLY, EMMA K.

2. DATE OF DEATH: JAN. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days: Unknown

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 27-06
D. STREET ADDRESS (If rural, give location): 6026 OLD HARFORD Rd.

5. SEX: F
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: Aug 26, 1864
9. AGE (In years last birthday): 85
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: PETERS, HENRY
14. MOTHER'S MAIDEN NAME: FUNT, ANNIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. George Rohe — ADDRESS: 6026 OLD HARFORD Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

(B) Unknown

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. UREMIA

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): NONE
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN. 3, 1950 *to* JAN. 6, 1950 *that I last saw the deceased alive on* JAN 6, 1950, *and that death occurred at* 2:03 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: George W Bohne M. D.
23B. ADDRESS: Franklin Sq Hosp
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: Rosehill Cem.
24D. LOCATION (City, town, or county) (State): Altoona - Pa.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: Leonard J. Buck — ADDRESS: 5305 HARFORD Rd.

VS 150

122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be ... supplied. The MARGIN RESERVED FOR BINDING ... correct age is especially important. Physicians: please write the causes of death clearly and ...

50 P-362 0165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4/20/50 0165

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles E. Peterson

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-44
D. STREET ADDRESS (If rural, give location): 3110 Evergreen Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 28-1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Un. Shoe Machinery
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Peterson
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Son in law ADDRESS: Robert Ellis 3110 Evergreen Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary [redacted] Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
DUE TO
(B) — INTERVAL:
DUE TO
(C) — INTERVAL:

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis — INTERVAL: 7-8 yrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7 (3 AM) 1950, *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 7 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Margaret L. Sherrard M. D.
23B. ADDRESS: Mercy H
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford

JAN 8 1950

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-632 66 50 0166

BIRTH NO. 50 0166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mae G. Bradyhouse

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3520 N. Hilton Street
C. Length of stay in Baltimore: 60 Shriner's Nursing Home 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2401 Garrison Avenue 27-15

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: ------
9. AGE (In years last birthday): About 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Government
10B. KIND OF BUSINESS OR INDUSTRY: Clerk
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Bradyhouse
14. MOTHER'S MAIDEN NAME: Mathilda Dunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thomas Chase ADDRESS: 2023 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/24, 1949 *to* 1/6, 1950, *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 6:40 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert A. Reiter M. D.
23B. ADDRESS: 3408 Windsor Ave.
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Nuning for Nafiamma, M.D.
25. FUNERAL DIRECTOR: W. W. Wagner and Son
ADDRESS: 805 N. Calvert St.

VS 150

26695 937

G-526 X 6? 50 0167

50 0167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gingrich, Eva Mae

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Maryland
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location): –

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: March 2, 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: –
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Henry
14. MOTHER'S MAIDEN NAME: W. Renn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): –
16. SOCIAL SECURITY NO.: –
17. INFORMANT: Patient ADDRESS: Owings Mills

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of colon — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Jan. 2, 1950
19B. MAJOR FINDINGS OF OPERATION: Distention of colon
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): –
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): –
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): –

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: –
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? –

22. *I hereby certify that I attended the deceased from* Dec. 31, 1949, *to* Jan 6, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ellen G. Bennet M. D.
23B. ADDRESS: Women's Hospital Balto
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 9-1950
24C. NAME OF CEMETERY OR CREMATORY: Pleasant Hill Cemetery
24D. LOCATION (City, town, or county) (State): Owings Mills Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Phillip J. Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Benyman & Sons ADDRESS: Reisterstown, Md.

VS 150

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5532

50 0168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

177

Registered No. 50 0168

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert L. Schmitz

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2719 W Lafayette Ave
C. Length of stay in Baltimore: 24 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore Md
B. COUNTY: 2719 W Lafayette Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 16-06
D. STREET ADDRESS (If rural, give location): 2719 W Lafayette Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Aug 11-1897
9. AGE (In years last birthday): 52 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furniture Upholst
10B. KIND OF BUSINESS OR INDUSTRY: Home Foundry
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore Schmitz
14. MOTHER'S MAIDEN NAME: Mary A Cassady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-1188
17. INFORMANT: Marie Schmitz — ADDRESS: 2719 Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate — Metastasis to Spine — INTERVAL BETWEEN ONSET AND DEATH: 2 years.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: May 1948
19B. MAJOR FINDINGS OF OPERATION: Metastatic Carcinoma of spine
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1948, 19__, to Jan 5, 1950, that I last saw the deceased alive on Jan 4, 1950, and that death occurred at 3:40 m., from the causes and on the date stated above.

23A. SIGNATURE: Wm J Schmidt M. D.
23B. ADDRESS: 701 N. Fremont Ave
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 - 1950
REGISTRAR'S SIGNATURE: Lemington Hillquit
25. FUNERAL DIRECTOR: Chas M Taylor
ADDRESS: 2447 Edmondson Ave

VS 150

51B

Renewed a
clerc 0207-

rec -
118 Richmond Rd
January 14 93

W-314
50 0169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 50 0169 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): J. Howard Wiedefeld

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4034 Hayward Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4034 Hayward Ave 27-18

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 10, 1893
9. AGE (In years last birthday): 56 — If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: House Painter(Self)
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: William J. Wiedefeld
14. MOTHER'S MAIDEN NAME: Frances R. Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-10-2373
17. INFORMANT: Mrs. Howard Wiedefeld — ADDRESS: 4034 Hayward Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: Dec 29, 1949 to Jan. 6, 1950

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive C V D

DUE TO

(C) chronic myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Asphyxia

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 24, 1949 *to* 1-6, 1950, *that I last saw the deceased alive on* 1-6, 1950, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lawrence J Chmanek M. D.
23B. ADDRESS: 3711 Falls Rd
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 8 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld — ADDRESS: 900 E. Biddle St

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-143

50 0170

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~41 Registered No. 50 0170

1. NAME OF DECEASED (Type or Print): George Henry Beaufelter

2. DATE OF DEATH: Jan. 6 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 820 Whitmore Ave Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 60 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 820 Whitmore Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 7 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Singer Sew. Mach. Salesman
11. BIRTHPLACE (State or foreign country): Frederick, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Beaufelter
14. MOTHER'S MAIDEN NAME: Jennette Fraley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Florence C Beaufelter ADDRESS: 820 Whitmore Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 30 min

DUE TO

(B) Asthma — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1-1949, 19__, *to* Jan 6, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: C J Mendelis M. D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Hogarth & Pillard ADDRESS: 2503 Edmondson Ave

VS 150

298 78

112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-165

50 0171

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

450 50 0171
Registered No.

1. NAME OF DECEASED (Type or Print): PHILOMINA SPERANZELLA

2. DATE OF DEATH: JANUARY 4, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St JOSEPH'S HOSPITAL
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 3-02
D. STREET ADDRESS (If rural, give location): 417 S. Central ave

5. SEX: FEMALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: SEPT 9 1886
9. AGE (In years last birthday): 63 64. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CONTANZO DI SAIE
14. MOTHER'S MAIDEN NAME: STELLA MARIA CARDENGA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: CHARLES SPERANZELLA ADDRESS 417 S Central ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS

DUE TO

ANTECEDENT CAUSES

(B) DIABETES MELLITUS — 3 YRS

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) CIRRHOSIS OF LIVER — 1½ YRS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE, 1948, *to* JAN 4, 1950, *that I last saw the deceased alive on* JAN 4, 1950, *and that death occurred at* 11 40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: James F Kavanagh MD M. D.
23B. ADDRESS: 3014 McElderry St
23C. DATE SIGNED: 1-7-50.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN 9 1950
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BELAIR Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Mrs. Hilliard, Mgr.
25. FUNERAL DIRECTOR: Wendell J. Huppel
ADDRESS: 3128 Highland ave

VS 150

9th

61

JAN 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-252 50 0172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 50 0172

Registered No.

BIRTH NO. 50-00235

1. NAME OF DECEASED (Type or Print): BABY BOY WISNIEWSKI "B" 774

2. DATE OF DEATH: 1/5/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 BON SECOURS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days — life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto - 22 Dundalk
D. STREET ADDRESS (If rural, give location): 7609 Maple Rd

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: 1/5/50
9. AGE (In years last birthday): If Under 1 Year: Months — Days — Hours 0 Min. 18
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: MR. VICTOR WISNIEWSKI
14. MOTHER'S MAIDEN NAME: Elizabeth Abel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Victor Wisniewski ADDRESS: 7609 Maple Rd. 22

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 18 min.

DUE TO

(B) PREMATURITY

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 5, 1950 *to* Jan. 5, 1950, *that I last saw the deceased alive on* Jan. 5, 1950, *and that death occurred at* 10:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul G. Mannino M. D.
23B. ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Harry T. Leitzke ADDRESS: 4101 Edmondson Ave

VS 150

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-252

50 0173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 50 0173

Registered No.

BIRTH NO. 50-00236

1. NAME OF DECEASED (Type or Print): Baby Boy Wisniewski "A" 774

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
C. Length of stay in Baltimore: 22 hrs (Yrs. Mos. ~~Days~~)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore 22 Dundalk
D. STREET ADDRESS (If rural, give location): 7609 Maple Road

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1-5-50
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: 22 Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Victor Vincent Wisniewski
14. MOTHER'S MAIDEN NAME: Elizabeth Lettie Abell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: 7609 Maple Road
ADDRESS: Balt 22 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PRE-MATURITY

DUE TO "RESP. FAILURE"

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/5, 1950, *to* 1/6, 1950, *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 7:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William S. Womack M. D.
23B. ADDRESS: Bon Secours
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Harry H. Nuttle
ADDRESS: 4101 Edmondson Ave.

JAN 9 1950 Director for Williams, M.D.

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible].

50 0174 F-426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 026

50 0174 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward C. Folger

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 St. Paul Nursing Home 2305 St Paul St
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-07
D. STREET ADDRESS (If rural, give location): 1141 Ellicott Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 3/18/1892
9. AGE (In years last birthday): 57 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer
10B. KIND OF BUSINESS OR INDUSTRY: White Engineering Co
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Folger
14. MOTHER'S MAIDEN NAME: Flora (Unknown) ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Audrey Echner — ADDRESS: 205 S. Catherine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
(B) Unknown.
DUE TO
(C) C. N. S. Lues — 3 yr?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 1950, *to* Jan 6, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 12 5p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert B. Turner, M. D.
23B. ADDRESS: 920 So Paul So
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Mosland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Emily for Nellie
25. FUNERAL DIRECTOR: Wm Cook Sons
ADDRESS: 127 St Paul St.

VS 150

356 38

30C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1940 - 1 - 6
1892 - 3 - 18

57

50 0175 J-525 50 0175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

561.0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George A. Johnson

2. DATE OF DEATH: 1/4/50

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 MARYLAND Gen'l Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 22-02
D. STREET ADDRESS (If rural, give location): 556 Conway St.

5. SEX: M
6. COLOR OR RACE: Wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: April 23rd 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Bloomfield N.J.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Johnson
14. MOTHER'S MAIDEN NAME: Mary Meisner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Foster 11 N. 11th St. ADDRESS: Newark N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peripheral Vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs.

DUE TO

(B) Strangulated Inguinal Hernia — 5 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/3/49
19B. MAJOR FINDINGS OF OPERATION: Strangulated Ing Hernia; Gangrene - Small Bowel
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3, 1950 *to* 1/4, 1950, *that I last saw the deceased alive on* 1/4, 1950, *and that death occurred at* 6:25 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ernest A. Cerasano M. D.
23B. ADDRESS: Md. Genl Hosp
23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: St. Peters
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lexington Williams M.D.
25. FUNERAL DIRECTOR: Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 150

340V9 122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Box 9317

1946
75
1871

50 0176 W-160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. 50 0176

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter C. Weaver

2. DATE OF DEATH: Jan. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3325 Cliftmont Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/30/1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Street Car Operator
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Transit Co.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Weaver
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edward J. McKill
ADDRESS: 3325 Parklawn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Balto.
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Hunting for Nelson M.D.
25. FUNERAL DIRECTOR: W. Cook Dyer
ADDRESS: 1217 St. Paul St.

VS 151

45649 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

$$\frac{1949 - 60}{1889}$$

50 0177 D-620

50 0177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DORSEY, CARRIE ISABELLE

2. DATE OF DEATH: 1/7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident
C. Length of stay in Baltimore: ~~Yrs.~~ ~~Mos.~~ 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SYKESVILLE
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. COLOR OR RACE: Negro
7. (SINGLE) MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 11/11/46
9. AGE (In years last birthday): 3 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Everet Dorsey
14. MOTHER'S MAIDEN NAME: Isabelle Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Everet Dorsey — ADDRESS: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, Lobar — INTERVAL BETWEEN ONSET AND DEATH: (5 da.)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

~~493 X~~ 490 X

Query Measles

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5 *, 1950, to* 1/7 *, 1950 that I last saw the deceased alive on* 1/7 *, 1950 and that death occurred at* 8:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: St. Luke's
24D. LOCATION (City, town, or county) (State): Sykesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Hunter G. Torr, Reliquary, Md.
25. FUNERAL DIRECTOR: C. H. Wiser — ADDRESS: Sykesville, Md.

VS 150

108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See Document File 50-0177

4-19-50

Es

35089-13

C-500

BIRTH NO. 50 0178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

Registered No. 50 0178

1. NAME OF DECEASED (Type or Print): DAVID E. COHN

2. DATE OF DEATH: JAN. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Balt. Inc. 42
C. Length of stay in Baltimore: 46 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-05
D. STREET ADDRESS (If rural, give location): 2708 Reisterstown Rd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 63 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Hyman
14. MOTHER'S MAIDEN NAME: Reah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Reba Cohn — ADDRESS: 2708 Reisterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

ANTECEDENT CAUSES

(B) Cerebral degeneration — 6 mos.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerosis — 8 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/2 *, 1950, to* 1/8 *, 1950, that I last saw the deceased alive on* 1/8 *, 1950, and that death occurred at* 5:45 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Malcolm E. Ruben M. D.
23B. ADDRESS: Sinai Hospital, Balt.
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh
24D. LOCATION (City, town, or county) (State): Dallo Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin
ADDRESS: 2100 Eutaw Pl

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-264

BIRTH NO. 50 0179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 20.0

Registered No. 50 0179

1. NAME OF DECEASED (Type or Print): PAUL ASRAEL

2. DATE OF DEATH: 7 January 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 15-08A
D. STREET ADDRESS (If rural, give location): 3602 Duvall Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Shimmon
14. MOTHER'S MAIDEN NAME: Sarah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rose Asrael
ADDRESS: 3602 Duvall Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarct
DUE TO
(B) Coronary occlusion
DUE TO
(C) arterio-sclerotic heart dis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 12/29, 1949 to 1/7, 1950, that I last saw the deceased alive on 1/7, 1950, and that death occurred at 9.50 p.m., from the causes and on the date stated above.

23A. SIGNATURE: William Krakower M.D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young men
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Emmington Williams M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eutaw Pl

VS 150

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Jolles

50 0180

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.0

50 0180

Registered No.

1. NAME OF DECEASED (Type or Print): ABRAHAM Jolles

2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 27-57
D. STREET ADDRESS (If rural, give location): 4842 Pimlico Road

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 53 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington Ga
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Simon
14. MOTHER'S MAIDEN NAME: Hermine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sara Jolles ADDRESS: 4842 Pimlico Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO

(B) Coronary Thrombosis

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN 7, 1950, *to* JAN 8, 1950, *that I last saw the deceased alive on* Jan 8, 1950, *and that death occurred at* 1A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis Gramer M. D.
23B. ADDRESS: SINAI Hosp.
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eutaw Pl

JAN 9 - 1950

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M-460

BIRTH NO. 50 0181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E97

Registered No. 50 0181

1. NAME OF DECEASED (Type or Print): Sophia Muller N-968.0

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-01
D. STREET ADDRESS (If rural, give location): 715 N. Kenwood Ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Nov 6 1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months: 2, Days: — If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY: ✓

13. FATHER'S NAME: Bernard Hoffman
14. MOTHER'S MAIDEN NAME: Anna Grob

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Mildred Rix — ADDRESS: 1016 Ellicott Dr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 715 N. Kenwood Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 6, 1950 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Illuminating gas 4 burners and oven on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 10/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Allen Funeral Home — ADDRESS: 2008 Orleans

VS 151

163H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-550

50 0182

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

50 0182

Registered No.

1. NAME OF DECEASED (Type or Print): Charles G. Hohman

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 711 N. Broadway

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

C. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05

D. STREET ADDRESS (If rural, give location): 711 N. Broadway

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 3, 1861

9. AGE (In years last birthday): 88

If Under 1 Year: Months: Days

If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat packer retired

10B. KIND OF BUSINESS OR INDUSTRY: Meat

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Conrad Hohman

14. MOTHER'S MAIDEN NAME: Henrietta Kinsley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Estelle E. Vickers

ADDRESS: 711 N. Broadway

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Influenza — 10 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Yesr) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 23, 1949, *to* January 6, 1950, *that I last saw the deceased alive on* January 6, 1950, *and that death occurred at* 7.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert Eisenberg M. D.

23B. ADDRESS: 2025 E North Ave

23C. DATE SIGNED: January 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 9, 1950

24C. NAME OF CEMETERY OR CREMATORY: Baltimore

24D. LOCATION (City, town or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Ullrich Funeral Home

ADDRESS: 2008 Orleans St.

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

400

50 0183
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

452

50 0183
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): William Willey Hawley

2. DATE OF DEATH: Jan. 5, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
D. STREET ADDRESS (If rural, give location): 1638 E. Madison St.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 57
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Goldrock NC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Hawley
14. MOTHER'S MAIDEN NAME: Martha Ann.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-10-7064
17. INFORMANT: Sula Hawley
ADDRESS: 1638 E. Madison St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spontaneous subarachnoid hemorrhage from congenital aneurysm of circle of Willis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Aspiration of vomitous

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 9-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): A.A. Co., Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robert T. Williams
ADDRESS: 1515 McElderry St

VS 151

98899

83a

K-552

KAMINSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0184

BIRTH NO. 50 0184

1. NAME OF DECEASED (Type or Print): Josephine Kaminski

2. DATE OF DEATH: Jan. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged
C. Length of stay in Baltimore: Yrs. 70 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): Little Sisters of the Poor Home for Aged

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: Feb. 6 1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Valentine Parat
14. MOTHER'S MAIDEN NAME: Mary —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Hall — ADDRESS: 702 S. Eaton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) Arteio-Sclerosis — 5 yrs

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 1 *, 1950, to* Jan 7 *, 1950, that I last saw the deceased alive on* Jan 6 *, 1950, and that death occurred at* 5:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall M.D. M. D.
23B. ADDRESS: 1631 E North Ave
23C. DATE SIGNED: Jan 7-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mary Weber
ADDRESS: 401 S. Chester St.

VS 150

50 0183

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-455

CERTIFICATE CORRECTED 1-30-50

50 0185

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 50 0185

1. NAME OF DECEASED (Type or Print): William Henry SLOMAN

2. DATE OF DEATH: JAN. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2101 W. COLD SPRING LANE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): COLD SPRING NURSING HOME
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 710 E 20th St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: August 23 Jan 7, 1872
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10B. KIND OF BUSINESS OR INDUSTRY: B&O RR
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William D Sloman
14. MOTHER'S MAIDEN NAME: Christina Hager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Burns
ADDRESS: 710 E 20th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED - ARTERIOSCLEROSIS - ? yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 15, 1946, *to* Jan 7, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 3.45 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Norman R. Kleiman M. D.
23B. ADDRESS: 3803 Edmondson Ave
23C. DATE SIGNED: 1/7/50.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cole Inc
ADDRESS: 1217 S Paul St

VS 150 49614 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-256

LACHMAR

BIRTH NO. 50 0186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0186

1. NAME OF DECEASED (Type or Print): Edwin M. Lachmar Jr. 1

2. DATE OF DEATH: 1/7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospital
C. Length of stay in Baltimore: 7 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md Dundalk
D. STREET ADDRESS (If rural, give location): Dunkirk Apts, Dundalk

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Nov-5-1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10B. KIND OF BUSINESS OR INDUSTRY: Ship Yard
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: E. H. Lachenmayer
14. MOTHER'S MAIDEN NAME: Henrietta Leutdecher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 079-01-5016
17. INFORMANT: Mrs. Ellen Lee Herr
ADDRESS: 250 E. Main - Elkton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brongy Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. L. Schwab M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan-10-1950
24C. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery
24D. LOCATION (City, town, or county) (State): Easton, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: R. Ellis Clark
ADDRESS: Easton, Md.

VS 151

266 4V

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-450

50 0187
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 970

Registered No. 50 0187

1. NAME OF DECEASED (Type or Print): BETTE (Betty) Allen N-971.0

2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 2012 N. Calvert Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 42
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: -------
14. MOTHER'S MAIDEN NAME: -------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Catherine Freeney
ADDRESS: 7712 Linden Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Barbiturate poisoning

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2012 N. Calvert Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 6, 1950(?) ?m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ingestion of sleeping tablets

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 8 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: PAUL E. CHENOWITH, JR.
ADDRESS: 3615 Chestnut Ave.

VS 151

78071 1630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-455

50 0188

X

50 0188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMES Mary Bollman — 4yr. 1

2. DATE OF DEATH: 1-6-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 17 The Seton Institute
C. Length of stay in Baltimore: 4 Yrs. 21 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co. 18 Sudbrook Rd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville
D. STREET ADDRESS (If rural, give location): 18 Sudbrook Road, Pikesville.

5. SEX: F
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 6-17-1878
9. AGE (In years last birthday): 71 — If Under 1 Year: Months 6, Days 20 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school teacher
10B. KIND OF BUSINESS OR INDUSTRY: H.S.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Wendel Bollman
14. MOTHER'S MAIDEN NAME: Mary DeMangin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: The Seton Institute — ADDRESS: 6420 Reisterstown Rd Balto. 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis — 5 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senile Psychosis, paranoid type 1 year

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 15, 1949, *to* Jan. 6, 1950 *that I last saw the deceased alive on* Jan. 6, 1950 *and that death occurred at* 2:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm A. Rinn M. D.
23B. ADDRESS: Seton Institute Balto.
23C. DATE SIGNED: 1-6-50.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. Kernan Lemmon
ADDRESS: 4611 Park Heights

VS 150

V3491

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-626

BIRTH NO. 50 0189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0189

1. NAME OF DECEASED (Type or Print): Otto A. Kruger 4 yr. 1

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3300 Cardenas Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 24, 1889
9. AGE (In years last birthday): 60 yrs.
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: -- Kruger
14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. John M. Bierman
ADDRESS: 6619 Loch Hill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy / Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Jan. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Oaklawn Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Christopher Wilkins M.D.
25. FUNERAL DIRECTOR: C. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

346 V 9

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P. 220

50 0190

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0190

Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL A. PEACOCK

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4942 Reisterstown Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 4015 Sharon Ave.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 13, 1872
9. AGE (In years last birthday): 77 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Inspector(rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Peacock
14. MOTHER'S MAIDEN NAME: Margaret Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mabel Garrity
ADDRESS: 1222 Union Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 25, 1949, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 1950, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Manuel Levin M. D.
23B. ADDRESS: 4818 Reisterstown Rd
23C. DATE SIGNED: Jan. 8, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Stone Chapel Cem.
24D. LOCATION (City, town, or county) (State): Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Curtis T. Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

31847

93D

W-520 CERTIFICATE CORRECTED 1-11-1950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0191 — Registered No.

BIRTH NO. 50 0191

1. NAME OF DECEASED (Type or Print): JAMES NORMAN. WEEMS 4yo.

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP.
C. Length of stay in Baltimore: Yrs. Mos. Days LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BAL. TO. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE. - 15 28-01
D. STREET ADDRESS (If rural, give location): 4204 FERNHILL AVE.

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG 7, 1875
9. AGE (In years last birthday): 74 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE. Plant Supt.
10B. KIND OF BUSINESS OR INDUSTRY: (rtd) C. & P. Tel. Co
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES. N. WEEMS.
14. MOTHER'S MAIDEN NAME: MARGARET STENGEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: SAME — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial INFACTION

DUE TO

ANTECEDENT CAUSES

(B) Arterioselerotic cardiovascular diseas.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [1]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3, 1950, *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 5:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Marshall H. Carter Jr. M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11, 1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

15655 — 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

H-453

BIRTH NO. 50 0192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153 Registered No. 50 0192

1. NAME OF DECEASED (Type or Print): ANNA CATHERINE HOLLAND
2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3412 Woodbine Avenue
C. Length of stay in Baltimore: 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): 3412 Woodbine Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 26, 1870
9. AGE (In years last birthday): 79
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Richard ~~Barron~~ Murphy
14. MOTHER'S MAIDEN NAME: -- Barron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harry Holland (Son) ADDRESS: 3400 Woodbine Ave Baltimore 7, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Caycinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic cardiovascular Disease — 10 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 30, 1948 to Jan 7, 1950, that I last saw the deceased alive on Jan 7, 1950, and that death occurred at 3 p m., from the causes and on the date stated above.

23A. SIGNATURE: Millard T. Trabold M. D.
23B. ADDRESS: 3400 Woodbine Ave, Balt 7
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

0191 46E

D-500

CERTIFICATE CORRECTED 1-9-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No. 50 0193

BIRTH NO. 50 0193

1. NAME OF DECEASED (Type or Print): Teresa Theresa M. Dunn

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
48
C. Length of stay in Baltimore: 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-61
D. STREET ADDRESS (If rural, give location): 427 North Kenwood Ave 24

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 12-27-88
9. AGE (In years last birthday): 61 60 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Ritter
14. MOTHER'S MAIDEN NAME: Mary S. Hessler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret Driscoll, ADDRESS: 427 N. Kenwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

DUE TO

ANTECEDENT CAUSES

(B) Hypertensive cardiovascular disease — several years

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Glomerulonephritis Chronic — several years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia & pulmonary edema — Terminal

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-15, 1949 *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 3:48 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louisa Candler M. D.
23B. ADDRESS: Md. Gen'l Hosp.
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Old Fred'k Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

VS 150

131a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D-560

DeMORE

50 0194
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

19 Registered No. 50 0194

1. NAME OF DECEASED (Type or Print): Sister Adele De Moore

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 5 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): Charles & 28th St. 2800 N. Chas St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 10/20/1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINCIPAL
10B. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John V. de More
14. MOTHER'S MAIDEN NAME: Ella Dewey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: St. Agnes Hospt. ADDRESS: Caton & Wilkens Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Melanoma — Unknown
DUE TO
(B) Malignant Melanoma — 3 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bilateral Pleural Effusion

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-11-49, 19__, *to* 1-7-50, 19__, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 9:35 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert B. McFadden M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Remington Williams, M.D.
25. FUNERAL DIRECTOR: M. Faher & Sons
ADDRESS: 1827 W. North Ave

VS 150
V3491

53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I-6 30 GM. 50 130782 0195 343 50 0195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hugh D. Trott SR.

2. DATE OF DEATH: 1- 8- 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: ~~Life~~ ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annapolis MD.
D. STREET ADDRESS (If rural, give location): 10 Hyde ST. Annapolis MD.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1- 18- 1913
9. AGE (In years last birthday): 36 Yrs. If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter (Self)
10B. KIND OF BUSINESS OR INDUSTRY: House + General
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Trott
14. MOTHER'S MAIDEN NAME: Erma Phipps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

(B) Encephalitis of undetermined etiology ~~Meningitis, Organism Undeterminded~~ (prev)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1- 8- , 19 50 *to* 1- 8- , 50 , *that I last saw the deceased alive on* 1- 8- , 1950 *and that death occurred at* 6.45AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Chozen M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 1-8- 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 10 1950
24C. NAME OF CEMETERY OR CREMATORY: Drake Cem
24D. LOCATION (City, town, or county) (State): Drake. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Ethel Williams
25. FUNERAL DIRECTOR: Willis Emerson
ADDRESS: 4510 Liberty Heights Ave

VS 150 Lamington Williams, M.D.

340V9 80B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

See Document File
G 00195
1-11-50
ES

F 252

50 0196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0196

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): A. CORA FICKENSCHER Hro. 1

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 308 RIVERSIDE DRIVE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: OCT. 1 - 1891
9. AGE (In years last birthday): 58 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CHRISTIAN GARMAN
14. MOTHER'S MAIDEN NAME: KATIE E. BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert Hoch ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema and Shock — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Infarction — 4 hrs.

DUE TO

(C) Coronary Thrombosis — 4 hrs.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis; Diabetes; Obesity

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6- , 1950, *to* 1-6- , 1950, *that I last saw the deceased alive on* 1-6- , 1950, *and that death occurred at* 10:10A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: JAN. 9-50
24C. NAME OF CEMETERY OR CREMATORY: OAK LAWN
24D. LOCATION (City, town, or county) (State): EASTERN AVE Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Lawrence E. Williams, M.D.
25. FUNERAL DIRECTOR: John G. Connelly
ADDRESS: 410 Eastern Ave Balto 21 Md

JAN 9 1950

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0197

BIRTH NO. 50 0197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Alberta Tazen 788.6

2. DATE OF DEATH: 1-5-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 741 W. Lexington St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 741 W. Lexington

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 23, 1914
9. AGE (In years last birthday): 35
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Henderson, N. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Armstead Howell
14. MOTHER'S MAIDEN NAME: Lena
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Carl Tazen. ADDRESS: 741 W. Lexington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Faidoci
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4-, 1950, *to* 1-5-, 1950, *that I last saw the deceased alive on* 1-5-, 1950, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. E. Brady M. D.
23B. ADDRESS: President Hosp
23C. DATE SIGNED: 1-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 1-9-1950
24C. NAME OF CEMETERY OR CREMATORY: Henderson N.C.
24D. LOCATION (City, town, or county) (State): Henderson N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Mrs Peter R Williams
ADDRESS: 322 N Schroeder St

VS 150

Lexington / Alleman, M.

66B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-500 50 0198 HAM 50 0198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bettie Idam

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1515 Lamont St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1515 Lamont St.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 1515 Lamont St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1515 Lamont St.

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 28, 1896
9. AGE (In years last birthday): 53 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Darlington, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: January Brockington.
14. MOTHER'S MAIDEN NAME: Bettie Fountain.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Theo Mc Daniel. ADDRESS: 1515 Lamont St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chro. Hypertension - Cardiac — Unknown

DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) General senile changes — Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 10, 1949 to Jan 6, 1950, that I last saw the deceased alive on Jan 3, 1950, and that death occurred at 1:30 P m., from the causes and on the date stated above.

23A. SIGNATURE: John W. Gaines M. D.
23B. ADDRESS: 525 W. Hamburg St
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: Jan 9, 1950
24C. NAME OF CEMETERY OR CREMATORY: Darlington S.C.
24D. LOCATION (City, town, or county) (State): South Carolina

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Bettie R. Williams
ADDRESS: 322 N Schroeder St

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-525

50 0199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42

Registered No. 50 0199

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Johnson

2. DATE OF DEATH: 1/3/50

3. PLACE OF DEATH: A. Baltimore City, Maryland 1317 Madison Ave Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 Bar-Wilba Home

C. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: 25 N. Amity St

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md.

D. STREET ADDRESS (If rural, give location): 25 N. Amity St. 18-01

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
male	col	Widow	1875	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saloon

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Essex Co. Va.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Johnson

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Renal Disease

DUE TO

(B) Uremia - Gangrene of Leg, 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/2, 1950, *to* 1/3, 1950, *that I last saw the deceased alive on* 1/3, 1950, *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. Carson M. D.

23B. ADDRESS: 600 N Arlington Ave

23C. DATE SIGNED: 1/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-1950

24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950

REGISTRAR'S SIGNATURE: Lawrence Williams M.D.

25. FUNERAL DIRECTOR: Mr Kotis R. Williams

ADDRESS: 322 N Schroeder St

VS 150

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131a

S-140
50 0200

50 0200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SCHAUFELE Susie L. 491

2. DATE OF DEATH: Jan 6th 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Bellona & Belvedere Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 Edgewood Home

C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: ~~Towson Ave~~ ~~Md~~ BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Balto~~ COWENTON
D. STREET ADDRESS (If rural, give location): Towson Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 3rd 1866
9. AGE (In years last birthday): 83
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm. Levering
14. MOTHER'S MAIDEN NAME: Sarah Lathum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Velma Kirk ADDRESS: 614 Hollen Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

(B) ~~Bronchopneumonia~~, heart failure — 9 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) BRONCHOPNEUMONIA — 9 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senility — 13 yrs.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29 *,* 1949 *, to* Jan 6th *,* 1950 *that I last saw the deceased alive on* Jan 6 *,* 1950 *, and that death occurred at* 12:40 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: A. J. Charfauros M. D.
23B. ADDRESS: 6710 York Rd
23C. DATE SIGNED: Jan 7. 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 10th 1950
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem
24D. LOCATION (City, town, or county) (State): E. North Ave Extended

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lauchlin Williams, M.D.
25. FUNERAL DIRECTOR: Leo S. Leroch
ADDRESS: 1703 N. Patterson Park Ave

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-450

50 0201

50 0201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Whalen Mr. William

2. DATE OF DEATH: Jan 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hosp.
C. Length of stay in Baltimore: 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 19
D. STREET ADDRESS (If rural, give location): 612 F. Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 12, 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roll turner
10B. KIND OF BUSINESS OR INDUSTRY: Steel
11. BIRTHPLACE (State or foreign country): Sparrows Point
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Whalen, Mr. Thomas
14. MOTHER'S MAIDEN NAME: Ryan, Miss Delig
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-07-9661
17. INFORMANT: Whalen, Mrs. Helen
ADDRESS: 612 F. St. Balto. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion & Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

DUE TO

ANTECEDENT CAUSES

(B) Generalized Arterio sclerotic Cardio vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Many Yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 2, 1950, *to* Jan. 7, 1950, *that I last saw the deceased alive on* Jan 6, 1950 *and that death occurred at* 4:50 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: Church Home + Hosp
23C. DATE SIGNED: Jan 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: Oaklawn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E. Balto. St

49629

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W 500
50 0202

WINEOW

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0202
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Paul Wineow 332

2. DATE OF DEATH: 1-9-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Md.
C. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Allegany Cumberland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cumberland
D. STREET ADDRESS (If rural, give location): 216 Cumberland St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 60 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor
10B. KIND OF BUSINESS OR INDUSTRY: MFG. EXPLOSIVES
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Wineow
14. MOTHER'S MAIDEN NAME: Frances Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral infarction
DUE TO
(B) arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ~~Pulmonary~~ Pneumonitis

19A. DATE OF OPERATION: 12-1-49
19B. MAJOR FINDINGS OF OPERATION: cerebral infarction
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28, 1949 *to* 1-9, 1950 *that I last saw the deceased alive on* 1-9, 1950, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Romero Nichols M. D.
23B. ADDRESS: Cumberland Md.
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1-9-50
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Cumberland Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E Balto St.

VS 150

21017 83B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T-460

50 0203
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0203

1. NAME OF DECEASED (Type or Print): SAMUEL M. TAYLOR — 4/20.1
2. DATE OF DEATH: 1/7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 1416 Clarkson Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-01
D. STREET ADDRESS (If rural, give location): 1416 Clarkson Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 5/1/1882
9. AGE (In years last birthday): 67 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar Tender
10B. KIND OF BUSINESS OR INDUSTRY: Smoke's Restaurant
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Walter P. Taylor Sr.
14. MOTHER'S MAIDEN NAME: Agnes J. McCardell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-18-2591
17. INFORMANT: Family - Same — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis,

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) hypertension & Myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1949, *to* Jan 7, 1950, *that I last saw the deceased alive on* 1/5, 1950, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur C. Schenuch M. D.
23B. ADDRESS: 1337 S. Charles St
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lurington Williams
25. FUNERAL DIRECTOR: James L. McCauley
ADDRESS: 130 E. Fort Ave.

VS 150
71071
93D

W-452

BIRTH NO. 50 0204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1

Registered No. 50 0204

1. NAME OF DECEASED (Type or Print): CLARENCE J. WELLINGHAM

2. DATE OF DEATH: January 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2235 Frederick Avenue
C. Length of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-05
D. STREET ADDRESS (If rural, give location): 2235 Frederick Avenue

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 14, 1909
9. AGE (In years last birthday): 40
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Proprietor
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aubrey Willingham
14. MOTHER'S MAIDEN NAME: Emma Basque

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Vada M. Willingham
ADDRESS: 2235 Frederick Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Pryor M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan. 9, 1950
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Purcellville, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Livingston Williams, M.D.
25. FUNERAL DIRECTOR: George L. Schwab
ADDRESS: 2101 Frederick Ave

VS 151

15671

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-250

(5)

ROGAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E976

BIRTH NO. 50 0205 — Registered No. 50 0205

1. NAME OF DECEASED (Type or Print): William A. Rogan — N-853.4

2. DATE OF DEATH: Jan. 7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~918 Mt. Holly St.~~ W. Balto. Jail-Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-08
D. STREET ADDRESS (If rural, give location): 918 Mt. Holly St

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 20/88
9. AGE (In years last birthday): 61
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Keeper
10B. KIND OF BUSINESS OR INDUSTRY: John S. Wilson Co
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas W. Rogan
14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary Rogan — ADDRESS: 918 Mt. Holly St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): garage
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): rear of 918 Mt. Holly Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 7, 1950 ? a. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☑, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Rogan M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk.
24D. LOCATION (City, town, or county) (State): 3801 Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Kistle
ADDRESS: 4101 Edmondson Ave

V9151 21073 164c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-300

BIRTH NO. 50 0206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0206

1. NAME OF DECEASED (Type or Print): Charles Egbert Pitt 443

2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital 44
C. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 2702 Taylor Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 20, 1894
9. AGE (In years last birthday): 55 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter J. Pitt
14. MOTHER'S MAIDEN NAME: Alice V. Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or nokoown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Watson (son-in-law) ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 Months
DUE TO
(B) Hypertensive Heart Disease — Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2, 1950, *to* 1-8, 1950, *that I last saw the deceased alive on* 1-8, 1950, *and that death occurred at* 12 40 pm., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard Beach M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A. Deighte
ADDRESS: 4101 Edmondson Ave

VS 150

36233

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-620

BIRTH NO. 50 0207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0207

4 20,0

1. NAME OF DECEASED (Type or Print): Louise Elizabeth Kraus

2. DATE OF DEATH: Jan. 7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1401 Kingsway Rd. Northwood
C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-07
D. STREET ADDRESS (If rural, give location): 1401 Kingsway Rd, Northwood

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 27, 1865
9. AGE (In years last birthday): 84 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis H. Thomas
14. MOTHER'S MAIDEN NAME: Catherine Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Herman M. Kraus — ADDRESS: 1401 Kingsway Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Sclerosis & Arterio-sclerotic heart Disease — 5 Years

DUE TO

Arteriosclerosis (Generalized)

(C) Diabetes Mellitus — 6 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Appendical Abscess — 8 Weeks

19A. DATE OF OPERATION: 12/23/49
19B. MAJOR FINDINGS OF OPERATION: Incision & Appendical Abscess
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1945, to 1/7, 1950, that I last saw the deceased alive on 1/6, 1950, and that death occurred at 10 00 p.m., from the causes and on the date stated above.

23A. SIGNATURE: V. Drafton Hersperger M. D.
23B. ADDRESS: 214 Medical Arts Building
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Harry T. Kuttle — ADDRESS: 4101 Edmondson Ave.

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-250

BIRTH NO. 50 0208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0208

1. NAME OF DECEASED (Type or Print): JAMES NED MASON. 524225

2. DATE OF DEATH: JAN 9 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ky.
B. COUNTY: Boone
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Union
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.
8. DATE OF BIRTH: 5-21-31
9. AGE (In years last birthday): 18 19
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co. Kentucky
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Winston C. Mason
14. MOTHER'S MAIDEN NAME: Ruth Fothergill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure.
DUE TO
(B) Tumor region 3rd ventricle
DUE TO
(C) Brain, malignant

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION: 30 Dec 49 3 Jan 50
19B. MAJOR FINDINGS OF OPERATION: Tumor region 3rd ventricle Brain
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22-, 1949 *to* 1-9-, 1950, *that I last saw the deceased alive on* 1-9-, 1950 *and that death occurred at* 3:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert G. Feiler M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9 Jan 50.

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Jan 12-50
24C. NAME OF CEMETERY OR CREMATORY: ODD Fellows Cemetery
24D. LOCATION (City, town, or county) (State): Carrollton - Kentucky

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 5118 Gwynn Oak Ave 54B

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Letter in document file: 50-0208 3/8/50

T656

50 0209
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

353 50 0209
Registered No.

1. NAME OF DECEASED (Type or Print) WILLIE RUTH TURNER

2. DATE OF DEATH January 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02
D. STREET ADDRESS (If rural, give location) 1537 Argyle Avenue

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/18/1914
9. AGE (In years last birthday) 35
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lynchburg Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Younger
14. MOTHER'S MAIDEN NAME Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Clifford Turner ADDRESS 665 W-Barre St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia--during convulsion
DUE TO Idiopathic epilepsy

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE R B Fisher. M.D.
23B. CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 1-6-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/9/50
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR JAN 9 - 1950
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR J. Broadnax
ADDRESS 108 W Montgomery St

VS 151

77087 85

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-634

50 0210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 yr. 1

Registered No. 50 0210

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Treadwell, Mrs. Bertha

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days — Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1529 North Broadway

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: March 29, 1876
9. AGE (In years last birthday): 73
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Temple, Mr. Isaac
14. MOTHER'S MAIDEN NAME: Moore, Miss Susan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Stanley Treadwell
ADDRESS: 3166 Raven Wood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(B) Generalized arteriosclerotic cardiovascular Disease — Many Yrs.
DUE TO
(C) Diabetes Mellitus — Many Yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 30, 1949 *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 12:30 PM *from the causes and on the date stated above.*

23A. SIGNATURE: Donald Slaton M. D.
23B. ADDRESS: Church Home + Hosp.
23C. DATE SIGNED: Jan. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Christian Churchyard
24D. LOCATION (City, Town, or County) (State): Harford Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Lillington Williams M.D.
25. FUNERAL DIRECTOR: John R. Mahler
ADDRESS: 2334 Jefferson St.

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-625
50 0211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163

Registered No. 50 0211

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine E. Bergman (Bergmann)

2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Mercy Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. 37 Mos. Days Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. ~~COUNTY~~: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 19 S. Calhoun ST.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): (circled)
8. DATE OF BIRTH: 1884 Unknown
9. AGE (In years last birthday): 65 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry Kirchgassner
14. MOTHER'S MAIDEN NAME: Catherine Elanges
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patient — ADDRESS: 19 Calhoun St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7-50, 19__, *to* 1-8-50, 19__, *that I last saw the deceased alive on* 1-8, 19 50, *and that death occurred at* 2 45 pm., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Raskin, M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: London Park Cem.
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 470 Hollins St.

VS 150

B-300

CERTIFICATE CORRECTED 1-18-1950

50 0212

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H10

50 0212

Registered No.

1. NAME OF DECEASED (Type or Print): William Lee Boyd

2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3203 Virginia Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 3203 Virginia Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. ~~2, 1905~~ 22, 1904
9. AGE (In years last birthday): 45 yrs
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Money Order Dept
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Postal Dept.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William F. Boyd
14. MOTHER'S MAIDEN NAME: Nellie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Dorothy E. Boyd, 3203 Virginia Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Partial Heart disease — INTERVAL BETWEEN ONSET AND DEATH: Jun 11 1949

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 11, 1949 *to* January 7, 1950, *that I last saw the deceased alive on* Jan 7, 1950, *and that death occurred at* 12.30Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Alan D. Bubert M. D.
23B. ADDRESS: 4803 Park Heights Ave.
23C. DATE SIGNED: January 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10, 1950
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elbert L. Lampman
ADDRESS: 4510 Liberty Heights Ave.

VS 150

26695

92 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-155

50 0213
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41 3 50 0213
Registered No.

1. NAME OF DECEASED (Type or Print): MARY HOFFMAN
2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. 42 Mos. Days Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Md 10
D. STREET ADDRESS (If rural, give location): 339 S. Clinton Street

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3/2/17
9. AGE (In years last birthday): 32
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Hogan
14. MOTHER'S MAIDEN NAME: Virginia L. Eurick ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Hoffman
ADDRESS: 339 S. Clinton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RHD c̄ Multiple Pulmonary Emboli & Pulmonary atelectasis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26, 1949, *to* 1-8, 1950 *that I last saw the deceased alive on* 1-8, 1950, *and that death occurred at* 1 PM *p., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Kaj M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Baltimore - Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Christopher Williams M.D.
25. FUNERAL DIRECTOR: Leo J. Zeller
ADDRESS: 403 S. Wolfe St.

V9 150

95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-536

50 0214

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

453.1

Registered No. 50 0214

1. NAME OF DECEASED (Type or Print) STEVE DEMETRICIAN

2. DATE OF DEATH 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 BON SECOURS HOSP.
C. Length of stay in Baltimore UNKNOWN Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD 1-0
D. STREET ADDRESS (If rural, give location) 3107 ELLIOTT ST

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 7/30/1903
9. AGE (In years last birthday) 46
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10B. KIND OF BUSINESS OR INDUSTRY GEN. REPAIRS UNEMPLOYED
11. BIRTHPLACE (State or foreign country) AUSTRIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME SAM DEMETRICIAN
14. MOTHER'S MAIDEN NAME ANNA TERESCAVICH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. ?
17. INFORMANT SUSAN DEMETRICIAN
ADDRESS SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, severe — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Buerger's disease, lower extremities — 10 months.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 8 Jan. '50
19B. MAJOR FINDINGS OF OPERATION Exploratory - sympathetic chain removed, Mt. Sinai
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) NO
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1-6, 1950 to 1-8, 1950 that I last saw the deceased alive on 1-8, 1950, and that death occurred at 11:30 P m., from the causes and on the date stated above.

23A. SIGNATURE Joseph R. Doke M. D.
23B. ADDRESS Bon Secours Hospital
23C. DATE SIGNED 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/12/1950
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart
24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR JAN 9 - 1950
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Philip Feilerdnc
ADDRESS Balto.

VS 150 33645

83a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

A-352

50 0215
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 451

Registered No. 50 0215

1. NAME OF DECEASED (Type or Print): Howard L. B. Adams

2. DATE OF DEATH: 1/7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Mercy Hospital
C. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 5206 Catalpha Rd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 13, 1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City of Balto
10B. KIND OF BUSINESS OR INDUSTRY: Janitor
11. BIRTHPLACE (State or foreign country): Cambridge Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John E. Adams
14. MOTHER'S MAIDEN NAME: Abbie Virginia Cramer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Helen E. Adams
ADDRESS: 5206 Catalpha Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Myocardial Aneurysm

DUE TO

ANTECEDENT CAUSES

(B) Myocardial Infarction

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Coronary Thrombosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Septicemia
Polycystic Kidneys

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/2, 1949 *to* 2/2, 1950, *that I last saw the deceased alive on* 2/2, 1950 *and that death occurred at* 11:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Bonfiglio M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Rick
ADDRESS: 5305 Harford Rd

VS 150

74098

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D-243

50 0216
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43

50 0216
Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude R. DaShields

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 9-06
D. STREET ADDRESS (If rural, give location): 1820 E. 30th Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 12, 1890
9. AGE (In years last birthday): 59 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: Radio Mfg.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry DaShields
14. MOTHER'S MAIDEN NAME: Ida L. Grill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: P. AUGUST GRILL — ADDRESS: 613 Rosedale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/5, 1949, *to* 1/6, 1950, *that I last saw the deceased alive on* 1/6, 1950, *and that death occurred at* 10:33 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel P. Scalia M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 1/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: H. Howard Strong — ADDRESS: 3207 W. North Ave.

VS 150

210 35

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 50 0217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0217

1. NAME OF DECEASED (Type or Print): Bernard Sauerhoff

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 793 Carroll St.

5. SEX: M
6. COLOR OR RACE: W
7. (SINGLE, MARRIED, WIDOWED, DIVORCED) (Specify):
8. DATE OF BIRTH: Sept. 21, 1935
9. AGE (In years last birthday): 14
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Sauerhoff
14. MOTHER'S MAIDEN NAME: Frannie Decker.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Sauerhoff ADDRESS: 793 Carroll St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cranio cerebral injury
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Howard Co. Washington Blvd. near Rt.1, Dorsey Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 6, 1950 6:45 P.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Bus and bicycle collision

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 10, 1950
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Johns on & Long wood Avenue

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bader Wisselbaugh ADDRESS: 703 N. Henry St.

VS 151

170 C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-320
50 0218

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0218
Registered No.

1. NAME OF DECEASED (Type or Print): MARY CELESTE WATTS

2. DATE OF DEATH: Jan. 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 303 Mt. Holly St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20.07
D. STREET ADDRESS (If rural, give location): 303 Mt. Holly St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 27, 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Watts
14. MOTHER'S MAIDEN NAME: Celeste —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Alma Watts
ADDRESS: 303 Mt. Holly St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — years

DUE TO

(C) Chronic Myocarditis — years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1948, *to* Jan 6, 1950, *that I last saw the deceased alive on* Jan 6, 1950, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 651 N Bentalou
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950
REGISTRAR'S SIGNATURE: Harrington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Farley
ADDRESS: Fulton Ave. & Fayette St.

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

132

50 0219

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175

Registered No.

50 0219

1. NAME OF DECEASED (Type or Print): Sarah M. Harvey Loftus

2. DATE OF DEATH: 1/6/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 E. 20th St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 9.08
D. STREET ADDRESS (If rural, give location): 812 E. 20th St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 12/22/1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Kirkpatrick
14. MOTHER'S MAIDEN NAME: Mary Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John T. Harvey
ADDRESS: 812 E. 20th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Ovary — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

DUE TO

ANTECEDENT CAUSES

(B) Generalized Carcinomatosis — 1 mo.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-14, 1949 to 1-6, 1950, that I last saw the deceased alive on 1-6, 1950, and that death occurred at 4 p m., from the causes and on the date stated above.

23A. SIGNATURE: W. W. Flynn M. D.
23B. ADDRESS: 1N E. Chase St.
23C. DATE SIGNED: 1-7-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lincoln Williams, M.D.
25. FUNERAL DIRECTOR: Wm Bock Inc.
ADDRESS: 1217 St. Paul St.

VS 150

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49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-530
50 0220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0220
Registered No. 4201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NORMAN E. SMITH

2. DATE OF DEATH: January 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 616 E. Eager Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10.01
D. STREET ADDRESS (If rural, give location): 616 E. Eager Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1/11/1903
9. AGE (In years last birthday): 46
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Smith
14. MOTHER'S MAIDEN NAME: Mary Brackett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Herbert E. Smith
ADDRESS: Long Ft. Pasadena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Morland Park
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 151 42098 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-462

50 0221

BALTIMORE CITY HEALTH DEPARTMENT 331 50 0221

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ada Sollers / SOLLERS

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
C. Length of stay in Baltimore: 61 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-09
D. STREET ADDRESS (If rural, give location): 928 Mason Street MASON

5. SEX: F
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: april 3rd 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: G. H.
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Nelson Sollers.
14. MOTHER'S MAIDEN NAME: Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2-, 1950, *to* 1-6, 1950, *that I last saw the deceased alive on* 1-6, 1950, *and that death occurred at* 5:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucius A. Leeper M.D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: Jan 7, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm. A. Jackson
ADDRESS: 916 Penna ave

VS 150

77087

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0222 - 5-625 CERTIFICATE CORRECTED 50 0222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph E. Grogan

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-27
D. STREET ADDRESS (If rural, give location): 1302 N Longwood

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 2, 1908
9. AGE (In years last birthday): 41
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintainance
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore Police
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael E Grogan
14. MOTHER'S MAIDEN NAME: Mary Ellen French

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): x No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-03-9866
17. INFORMANT: Catherine R Grogan ADDRESS: (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Jan. 8, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 11, 1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: J. Melville Jenkins ADDRESS: 2713 Kirk

VS 151 336 98 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0223

J. 520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9160

Registered No. 50 0223

BIRTH NO.

1. NAME OF DECEASED (Type or Print): J. Edward Jones — N-947.2

2. DATE OF DEATH: Jan. 7/1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1812 Barclay St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12.05
D. STREET ADDRESS (If rural, give location): 1812 Barclay Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 30/1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sign Painter
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co. Retired 1939
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward C. Jones — Md.
14. MOTHER'S MAIDEN NAME: Unknown Harris — Md. ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-05-3690
17. INFORMANT: Thomas L. Jones — ADDRESS: 5515 Windemere Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio. Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

(B) Third Degree Burn of Right Arm & Chest — 5 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1812 Barclay St
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1-3-50 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Burned self lighting pipe

22. *I hereby certify that I attended the deceased from* 1-3, 1950, *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 9 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: P. D. Flynn M. D.
23B. ADDRESS: 11 E. Chase St.
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/1950
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: William Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 150 34058 (To be O.K. by CHIEF MED. EX.) O.K. Dr. Flynn

181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-350 50 0224 CERTIFICATE CORRECTED 1-13-1950 50 0224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E981.

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA M. PATTON

N-875.4

2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arbutus
D. STREET ADDRESS (If rural, give location): 3206 Rosalie Road

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3/11/1925
9. AGE (In years last birthday): 24 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Philadelphia Pa
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles E Stinesmire
14. MOTHER'S MAIDEN NAME: Lucy Walker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-16-7136
17. INFORMANT: Charles E Stinesmire, ADDRESS: 1506 Clifton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple gunshot injuries of chest
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5206 Rosalie Road, Arbutus
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 7, 1949 approx. 11 a m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms (Shot during altercation)

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: R. H. Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Mem. Cem.
24D. LOCATION (City, town, or county) (State): Washington Blvd. & Dorsey Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Bolgano & Sons
ADDRESS: 1217 St. Paul St

VS 151 78071 166

2463-5

D-255

50 0225

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0225

Registered No.

1. NAME OF DECEASED (Type or Print): Bessie K. Dishman 153X

2. DATE OF DEATH: 1-9-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days: 43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 1921 Queensway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: Oct. 15, 1894
9. AGE (In years last birthday): 55 56 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Gilley
14. MOTHER'S MAIDEN NAME: Mary (Unknown) Gilley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Friedel — ADDRESS: 1917 Queensway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) primary site: - sigmoid colon

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) m. OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/23/49, 19__, *to* 1-9, 1950, *that I last saw the deceased alive on* 1-9, 1950, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: John A. Sarno M. D.
23B. ADDRESS: 1213 Light St.
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Lack Inc.
ADDRESS: 217 S. Paul St.

VS 150

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See Document File 50-0225
2-16-50
CS

B-400

50 0226

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.0

50 0226

Registered No.

1. NAME OF DECEASED (Type or Print): Catherine Bailey

2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: 79? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 4801 York Rd H 12

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Sept 4, 1870
9. AGE (In years last birthday): 79 | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Samuel H Beall
14. MOTHER'S MAIDEN NAME: Charlotte E Wilgis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia + congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos? unknown

DUE TO

(B) Nephrosclerosis Arteriosclerotic heart disease — ? years

DUE TO

(C) Generalized arteriosclerosis — ? years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Terminal pneumonia — 7-8 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7, 1949, *to* 1-8, 1950, *that I last saw the deceased alive on* 1-8-50, 19__, *and that death occurred at* 3 30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Cadle M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion
24D. LOCATION (City, town, or county) (State): Harford Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Henry W Jenkins & Sons Co.
ADDRESS: 4905 York Rd.

VS 150

131a

50 0227

BRYSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 50 0227

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 912 Arlington Ave N.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 16-01

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 912 Arlington Ave N.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bryson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Veronica Bryson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 59 Months Days If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business Monumental Tourist Co

FATHER

12. Name Charles F Bryson

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Alice Clay

15. Birthplace Baltimore Md

16 (a) Informant Veronica Bryson

(b) Address 912 arlington ave

17 (a) Burial (b) Date thereof Jan 13-1949
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto Md

18 (a) Funeral director Vg Brooks

(b) Address 1463 N. Carey St

19 (a) (b)
(Date received by registrar) Registrar

JAN 10 1950 Lucius Williams, M.D.

VS 150 42049

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1950, at 12:25 pm

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1949, to 1-8 1949, and that I last saw him alive on 1-8 1950.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M E Wilson M. D.

Address 803 W Fremont Date signed 1-9-50

83a

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

S-550

50 0228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

970.2

50 0228

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GLADYS O. SCHUMAN

N-971.0

2. DATE OF DEATH: January 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Tuscany Apartments 40th St. & Stoney Run Lane
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
12-01
D. STREET ADDRESS (If rural, give location): Tuscany Apts., 40th St. & Stoney Run La.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 6, 1901
9. AGE (In years last birthday): 48 yrs. If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: -- Christoffersen
14. MOTHER'S MAIDEN NAME: Belle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. George H. Schuman
ADDRESS: Tuscany Apts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Barbiturate poisoning

DUE TO

ANTECEDENT CAUSES

(B) Acute alcoholism

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 40th Street & Stoney Run Lane
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 8, 1950 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of sleeping tablets

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [X], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl K. Sayer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

163B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-400

50 0229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4200 50 0229

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha Virginia Diehl

2. DATE OF DEATH: 1-9-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): Northway Apartments

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 8, 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Nusbaum
14. MOTHER'S MAIDEN NAME: Lena Greenebaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. John L. Peck
ADDRESS: 5506 Lombardy Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic Heart Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Polycystic Kidneys, bilateral

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1950, *to* 1-9, 1950, *that I last saw the deceased alive on* 1-9, 1950, *and that death occurred at* 11:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Cost M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-420

50 0230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

Registered No.

50 0230

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Aleck

2. DATE OF DEATH: Jan. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11, Md. 27-06
D. STREET ADDRESS (If rural, give location): 2720 Bayonne Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 4, 1926
9. AGE (In years last birthday): 23 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant seaman
10B. KIND OF BUSINESS OR INDUSTRY: Shipping
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theodore Aleck
14. MOTHER'S MAIDEN NAME: Kay Kourja

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Medical records, US Marine Hospital — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral glomerulonephritis with secondary hypertensive cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 23, 19~~50~~ 49 *to* Jan. 7, 1950, *that I last saw the deceased alive on* Jan. 7, 1950, *and that death occurred at* 8:40P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Gust W. Sessoms M. D.
23B. ADDRESS: U.S. Marine Hospital
23C. DATE SIGNED: Jan. 8. 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-50
24C. NAME OF CEMETERY OR CREMATORY: Greek Cem
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Langbein Inc — ADDRESS: 1140 E. North ave

VS 150

46051

131B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M-000

50 0231

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H43

50 0231

Registered No.

1. NAME OF DECEASED (Type or Print): ANNA THEADORA MAY

2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 10 S. Conklin Street
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-08
D. STREET ADDRESS (If rural, give location): 10 S. Conklin Street

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec. 26, 1876
9. AGE (In years last birthday): 73 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Myers
14. MOTHER'S MAIDEN NAME: Mary Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 10 S. Conklin ~~Street~~ -24 Mrs. Virginia Robinson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. disease
DUE TO
coronal sclerosis
Carcinoma prostate

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1945, *to* 1/7, 1950, *that I last saw the deceased alive on* 1/7, 1950, *and that death occurred at* 11 m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Goodman M. D.
23B. ADDRESS: 3400 E. Pratt St
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lucington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-400

BIRTH NO. 50 0232

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0232

1. NAME OF DECEASED (Type or Print): MRS. MAUD EMMA REAL

2. DATE OF DEATH: January 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland St Joseph's Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days — Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-05
D. STREET ADDRESS (If rural, give location): 1319 Homestead Street

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 19, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Hagner
14. MOTHER'S MAIDEN NAME: Nellie Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: William J. Real
ADDRESS: 1319 Homestead St. 18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Renal Failure
DUE TO
(B) Renal Colcili
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: January 7, 1950
19B. MAJOR FINDINGS OF OPERATION: Renal Colcili
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 4, 1950, *to* January 8, 1950, *that I last saw the deceased alive on* Jan. 8, 1950, *and that death occurred at* 11:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Vito L. Coppa M. D.
23B. ADDRESS: St Joseph's Hospital
23C. DATE SIGNED: Jan 8, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lenington Williams M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: 5 E. Lanvale

VS 150

BALTIMORE - 13, MARYLAND 134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-210

50 0233

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.1

50 0233

Registered No.

1. NAME OF DECEASED (Type or Print): Leonard Bishop

2. DATE OF DEATH: Jan. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1422 Argyle Ave.

5. SEX: M
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 15, 1894
9. AGE (In years last birthday): 55
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Co.
11. BIRTHPLACE (State or foreign country): Greenwee S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lucy E. Bishop. ADDRESS: 1422 Argyle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 1950, *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 3:40 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucius W. Leeper M.D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: Jan. 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Nahi R. Williams
ADDRESS: 322 N. Schroeder St.

VS 150

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93E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-365
50 0234

50 0234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

603

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): STRONG, RUTH E.

2. DATE OF DEATH: 1/8/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT
C. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 16-01
D. STREET ADDRESS (If rural, give location): 1208 MOSHER

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4/16/22
9. AGE (In years last birthday): 27
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Elliott.
14. MOTHER'S MAIDEN NAME: Ruth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joe Strong. ADDRESS: 1208 Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~RE~~ UNDETERMINED

DUE TO

(B) Renal Insufficiency

DUE TO

(C) Mild cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/3, 1949, *to* 1/8, 1950 *that I last saw the deceased alive on* 1/2, 1949, *and that death occurred at* 6 40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. H. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lunington Williams M.D.
25. FUNERAL DIRECTOR: Mae Katie R Williams
ADDRESS: 322 N Schroeder St

VS 150

133B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

536

50 0235

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60

50 0235

Registered No.

1. NAME OF DECEASED (Type or Print): Onest Sanders. 525196

2. DATE OF DEATH: JAN 8 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-02A
D. STREET ADDRESS (If rural, give location): 426 Swale Ave., Md.

5. SEX: female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5-29-08
9. AGE (In years last birthday): 41 42 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Chesterfield N.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sanders Spencer
14. MOTHER'S MAIDEN NAME: Emma Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Pentothal anesthesia for F-D of colon

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus + nephrosis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6- 1950 *to* 1-8- 1950 *that I last saw the deceased alive on* 1-8- 1950, *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Cotton Owens M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cem.
24D. LOCATION (City, town, or county) (State): Lansdowne Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Emily for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams
ADDRESS: 322 N Schroeder St.

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H+ 200

BIRTH NO. 50 0236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E981

Registered No. 50 0236

1. NAME OF DECEASED (Type or Print): CHARLES HAYES

N-806.

2. DATE OF DEATH: January 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1910 Mosher Street
c. Length of stay in Baltimore (Yrs. Mos. Days):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 1910 Mosher Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Sept. 16, 1933
9. AGE (In years last birthday): 16
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert J. Hayes
14. MOTHER'S MAIDEN NAME: Mary L Mack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Albert Hayes
ADDRESS: 1910 Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Extensive decubitus ulcers

DUE TO

(B) Paraplegia

DUE TO

(C) Gunshot wound of Spinal Cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Rear of 1000 N. Stricker St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-29-48 12:45 p. m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-1950
24C. NAME OF CEMETERY OR CREMATORY: W. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mr Katie B. Williams
ADDRESS: 3228 Schroeder St

VS 151

166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-520

50 0237

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 21

50 0237

Registered No.

1. NAME OF DECEASED (Type or Print): VIOLA HARMON KNOX

2. DATE OF DEATH: January 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 680 W. Mulberry St
C. Length of stay in Baltimore: over 20 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 680 W. Mulberry St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 6, 1901
9. AGE (In years last birthday): 48
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10B. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Accomac Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Knox
14. MOTHER'S MAIDEN NAME: Annie Laws

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Ella Simpson
ADDRESS: 3022 Smith Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C. vascular disease of heart — INTERVAL BETWEEN ONSET AND DEATH: 8 years

DUE TO

(B) Cerebral hemorrhage — 9 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

arterio sclerosis — 5 years

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2-, 1950, *to* 1-9-, 1950, *that I last saw the deceased alive on* 1-9-, 1950, *and that death occurred at* 12:55p. *m., from the causes and on the date stated above.*

23A. SIGNATURE: John E. S. Pamper M. D.
23B. ADDRESS: 639 N. Carey St
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-1950
24C. NAME OF CEMETERY OR CREMATORY: M.E. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Cedy Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lincoln Williams, M.D.
25. FUNERAL DIRECTOR: Wm Kahle R. Williams
ADDRESS: 322 N. Schroeder St

VS 150 77087

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D# 263

50 0238
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56.1

50 0238
Registered No.

1. NAME OF DECEASED (Type or Print): HENRIETTA REBECCA DOUGHERTY

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1927 Druid Hill Ave.
c. Length of stay in Baltimore: 38 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1927 Druid Hill Ave

14-03

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 23, 1911
9. AGE (In years last birthday): 38
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Hall
14. MOTHER'S MAIDEN NAME: Hattie Spadey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James H. Dougherty
ADDRESS: 1927 Druid Hill Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Jejun.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Minor Operation
19B. MAJOR FINDINGS OF OPERATION: Johns Hopkins Hosp.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1 *,* 19 50 *, to* 1/8 *,* 19 50 *, that I last saw the deceased alive on* 1/8 *,* 19 50 *, and that death occurred at* 10 p.m. *, from the causes and on the date stated above.*

23A. SIGNATURE: B. W. Leila Sr. M.D.
23B. ADDRESS: 2139 Druid Hill Ave
23C. DATE SIGNED: 1/10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lurlington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 2160 Druid Hill Ave.

VS 150

46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H- 263

50 0239

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

526

Registered No. 50 0239

1. NAME OF DECEASED (Type or Print): EUGENE JOSEPH HEGARTY

2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): YMCA

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11/26/06
9. AGE (In years last birthday): 42 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AB seaman
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugene Hegarty
14. MOTHER'S MAIDEN NAME: Mary Dally

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 197-05-7683
17. INFORMANT: Records - US Marine Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Postoperative shock. — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

(B) Bronchiectasis. 1 — unk

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) XXXXX

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION: 1/9/50
19B. MAJOR FINDINGS OF OPERATION: as above
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 3, 1949, *to* Jan. 9, 1950 *that I last saw the deceased alive on* Jan. 9, 1950, *and that death occurred at* 11:55AM, *from the causes and on the date stated above.*

23A. SIGNATURE OF M. D.: R. C. Rodger
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Philadelphia PA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: Billy Zeider Inc
ADDRESS: 403 S. Wolfe St (31)

VS 150

46051

106B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C-626

BIRTH NO. 50 0240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33

Registered No. 50 0240

1. NAME OF DECEASED (Type or Print): MARTHA S. CREGGER

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5440 Belair Road
C. Length of stay in Baltimore: 1 Yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenarm
D. STREET ADDRESS (If rural, give location): None

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept. 30, 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Cregger
14. MOTHER'S MAIDEN NAME: Celia Shupe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Dorothy Cregger, ADDRESS: 317 Woodlawn Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO

ANTECEDENT CAUSES

(B) Arterial hypertension — 10 yrs +

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Cerebral arteriosclerosis — 10 yrs +

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Decubitus ulcers sacral area and cellulitis — 1 mo.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 1, 1947, *to* Jan. 10, 1950, *that I last saw the deceased alive on* Jan. 8, 1950, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John W. Machen M. D.
23B. ADDRESS: 6331 Belair Rd. (6)
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Chatam Hill
24D. LOCATION (City, town, or county) (State): Chatam Hill, Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

VS 150

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

320

BIRTH NO. 50 0241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41

Registered No. 50 0241

1. NAME OF DECEASED (Type or Print): JOSEPH F. LUDWIG SR.

2. DATE OF DEATH: 1/8/50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital North Broadway - Baltimore 31. Md
c. Length of stay in Baltimore: Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 636 S. Ellwood Ave. Balt
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 1-02
D. STREET ADDRESS (If rural, give location)

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10-21-1896
9. AGE (In years last birthday): 53. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist.
10B. KIND OF BUSINESS OR INDUSTRY: CONTINENTAL CAN
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm Ludwig
14. MOTHER'S MAIDEN NAME: Mary Kerp.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 214-03-4404
17. INFORMANT: JOSEPH F. LUDWIG JR. ADDRESS: 636 S. Ellwood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of tongue c̄ spread

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Extensive ~~[illegible]~~

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Nil
19B. MAJOR FINDINGS OF OPERATION.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27, 1949 *to* 1-8, 1950, *that I last saw the deceased alive on* 1-8, 1950 *and that death occurred at* 12:50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: W. Mitchener Jr. M. D.
23B. ADDRESS: C Church Home Hospital
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-12-50.
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEM.
24D. LOCATION (City, town, or county) (State): GERMAN HILL RD. BALTO CO., MD

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles B. Zeiler
ADDRESS: 901 S. Conkling St.

VS 150 3263V

45B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-260

50 0242
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0242

1. NAME OF DECEASED (Type or Print): J. CARL FISHER

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 208 Witherspoon Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 208 Witherspoon Rd.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 9, 1893
9. AGE (In years last birthday): 56 yrs.
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Customer Relations
10B. KIND OF BUSINESS OR INDUSTRY: Dpt. - Gas & Elec
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Burke Fisher
14. MOTHER'S MAIDEN NAME: Addie E. Toms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-05-6503
17. INFORMANT: Mrs. Henry C. Decker
ADDRESS: 208 Witherspoon Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V.D.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/9, 1947 *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 12:45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: C. Edward Leach M. D.
23B. ADDRESS: 14 E. Eager St.
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150
266 59

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-200

50 0243
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

415

Registered No. 50 0243

1. NAME OF DECEASED (Type or Print): William Denny Shuck

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1925 Park Ave.
C. Length of stay in Baltimore: 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02
D. STREET ADDRESS (If rural, give location): 1925 Park Ave.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug.14,1886
9. AGE (In years last birthday): 63 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: Shipping clerk
11. BIRTHPLACE (State or foreign country): St.Michael, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Thomas Shuck
14. MOTHER'S MAIDEN NAME: Anna Elizabeth Kirby
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): First World War
16. SOCIAL SECURITY NO.: 218-03-6555
17. INFORMANT: Lee Shuck
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Coronary disease — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
ANTECEDENT CAUSES
(B) Chr. Rheumatic Heart & Myocarditis — 35 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Grippe — 3 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2- 50, *to* 1-10- 50, *that I last saw the deceased alive on* 1-8- 50, *and that death occurred at* 1 A.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1901 Eutaw Pl. City
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Episcopal
24D. LOCATION (City, town, or county) (State): St.Michaels, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Norman D. Marshall
ADDRESS: St.Michaels, Md.

VS 150

22699 93C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0244 — Registered No. 50 0244

1. NAME OF DECEASED (Type or Print): Eugene Brooks

2. DATE OF DEATH: 1/9/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3300 Ravenwood Avenue

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 5, 1900
9. AGE (In years last birthday): 50 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher
10B. KIND OF BUSINESS OR INDUSTRY: A. & P.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eugene Brooks
14. MOTHER'S MAIDEN NAME: Catherine Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary A. Brooks — ADDRESS: 3300 Ravenwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R. Weiss, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Thurlington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck — ADDRESS: 5305 Harford Road

VS 151

45261 94a

P-623

BIRTH NO. 50 0245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0245

1. NAME OF DECEASED (Type or Print): SALVATORE PRESTI

2. DATE OF DEATH: 1-9-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. Joseph Hospital
c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-04
D. STREET ADDRESS (If rural, give location): 2847 Greenmount ave.

5. SEX: MALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/19, 1882
9. AGE (In years last birthday): 67 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barbar (Retired)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Presti
14. MOTHER'S MAIDEN NAME: Anna ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Dr. Joseph Presti ADDRESS 2847 Greenmount ave.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peripheral circulatory failure

DUE TO

ANTECEDENT CAUSES

(B) Acute Coronary Thrombosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9, 1950, *to* 1-9, 1950, *that I last saw the deceased alive on* 1-9, 1950, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan M. D.
23B. ADDRESS: St. Joseph's Hospital
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Chas. J. Evans, Sr. Inc.
ADDRESS: 118 N. Mt. Royal Ave.

VS 150

70089

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B 134763

50 0246

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 50 0246

1. NAME OF DECEASED (Type or Print): Jerry Twitty

2. DATE OF DEATH: 1-7-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 22yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 510 S. Paca St.

5. SEX: M
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 15- 1900
9. AGE (In years last birthday): 49 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Genl.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jerry Twitty
14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records: Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema and Uremia

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerotic cardio vascular disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6- *, 19*50 *to* 1-7- *, 19*50*, that I last saw the deceased alive on* 1-7- *, 19*50*, and that death occurred at* 12.50 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-7-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn St
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: D. L. Davis & Son 1082 W
ADDRESS: Montgomery St

VS 150 98899

To be approved by the Medical Examiner

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NOT A MEDICAL EXAMINER'S CASE

R B Fisher M.D.

CHIEF OR ASS'T. MEDICAL EXAMINER

610

50 0247
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0247

1. NAME OF DECEASED (Type or Print): SAMUEL TRIPPE
2. DATE OF DEATH: January 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1904 W. North Avenue

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12-27-1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY: LODGE
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stepney Trippe
14. MOTHER'S MAIDEN NAME: Mary J. Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Pearl Brown ADDRESS: 1904-W.North Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive heart failure
DUE TO Myocardial degeneration

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp& Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Pryer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National Ct.
24D. LOCATION (City, town, or county) (State): Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: J. L. Byron & Son - Montgomery St. 108 W.
ADDRESS

VS 151 740 94 93 D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

C-455

BIRTH NO. 50 0248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

007

Registered No. 50 0248

1. NAME OF DECEASED (Type or Print): DOUGLAS COLEMAN

2. DATE OF DEATH: January 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 14 W. York Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 44
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Hurlock Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bessie Hall
ADDRESS: 14 W. York Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Hillman, M.D.
25. FUNERAL DIRECTOR: L. L. Brown & Son
ADDRESS: 1082 Montgomery St

VS 151

98899

13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B-626
50 0249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 0249
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK BARKER

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ohio
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middletown
D. STREET ADDRESS (If rural, give location): 47 S. Main St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: 2/8/08
9. AGE (In years last birthday): 41
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired): FIREMAN FWT WATER TENDER
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Ky.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Miles Barker
14. MOTHER'S MAIDEN NAME: Belle Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 277-01-7298
17. INFORMANT: Records- US Marine Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

18. 280X

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism
DUE TO
Pulmonary edema

ANTECEDENT CAUSES

(B) cardiac decompensation
DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Benign heart disease

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 7, 1950, *to* Jan. 8, 1950, *that I last saw the deceased alive on* Jan. 8, 1950, *and that death occurred at* 5:20P *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, M. D.
John L. Wilson, Medical Director
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Woodside Cemetery
24D. LOCATION (City, town, or county) (State): Middletown, Ohio

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M. D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., 1217 St. Paul Street
ADDRESS:

VS 150
4451

95c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See Document File 50-0249
9-22-50

K-500

50 0250
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

151

50 0250
Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH T. KANE

2. DATE OF DEATH: Jan. 7, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1905 Hollins St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-03
D. STREET ADDRESS (If rural, give location): 1905 Hollins St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 7, 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Checker
10B. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Kane
14. MOTHER'S MAIDEN NAME: Lydia Hinton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Carolyn Kane
ADDRESS: 1905 Hollins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of Pyloric end of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 1/4 yrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Dec 1949
19B. MAJOR FINDINGS OF OPERATION: as above
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1949, *to* Jan 7, 1950, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: John F. Carlahan M. D.
23B. ADDRESS: 4201 Wilkens Ave
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Lamington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Mosley
ADDRESS: Fulton Ave & Fayette St.

VS 150
26661

463

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-260

50 0251

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17°

50 0251

Registered No.

1. NAME OF DECEASED (Type or Print): Alice Elizabeth Baker

2. DATE OF DEATH: Jan. 8 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2307 Aiken St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-08
D. STREET ADDRESS (If rural, give location) 2307 Aiken St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 31st 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert A. Dudley
14. MOTHER'S MAIDEN NAME: Alice B. Caffrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Geo. H. Baker
ADDRESS: 2307 Aiken St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of left breast — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: July 1944
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of left breast
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June *1944 to* Jan. 8 *, 1950 that I last saw the deceased alive on* Jan. 7 *, 1950, and that death occurred at* 12 4/5 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Grenzer M. D.
23B. ADDRESS: 1428 Hungerford Rd.
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Winington Williams, M.D.
25. FUNERAL DIRECTOR: E. J. Fanning & Son
ADDRESS: 1938 E. Lafayette Ave.

VS 150

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-162

50 0252

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 754.6 50 0252

Registered No.

1. NAME OF DECEASED (Type or Print): Molly A. Sprakes

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McLean
D. STREET ADDRESS (If rural, give location): Box 126

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 5-16-43
9. AGE (In years last birthday): 6 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dewey Sprakes
14. MOTHER'S MAIDEN NAME: Marion Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

(B) Transposition of Great Vessels — Congenital

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/10/50
19B. MAJOR FINDINGS OF OPERATION: Transposition of Great Vessels
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/ 30, 1950, *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 2:10 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: -
24D. LOCATION (City, town, or county) (State): Vienna, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 10 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons, North & Pa. Ave
ADDRESS:

VS 150

157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T. 512

50 0253

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0253

1. NAME OF DECEASED (Type or Print): LUTHER FRANKLIN THOMPSON

44r

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Matthews
D. STREET ADDRESS (If rural, give location): Blakes PO

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11/30/86
9. AGE (In years last birthday): 63 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Franklin Thompson
14. MOTHER'S MAIDEN NAME: Ida Virginia Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records- US Marine Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular renal disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 29, 19 49, *to* Jan. 10, 19 50, *that I last saw the deceased alive on* Jan. 10, 19 50, *and that death occurred at* 8:15A *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. N. Drake M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/10/50
24C. NAME OF CEMETERY OR CREMATORY: Blake, Va.
24D. LOCATION (City, town, or county) (State): Blake Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wm J. Tickner & Son
ADDRESS:

VS 150

13051

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D+ 100 50 0254 X 163 50 0254

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CALEB DAYHOFF

2. DATE OF DEATH: 1-10-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: ~~Yrs.~~ ~~Mos.~~ 33 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Wash.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerstown
D. STREET ADDRESS (If rural, give location): Route #5

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 1897
9. AGE (In years last birthday): 53 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Laborer~~ DRILLER
10B. KIND OF BUSINESS OR INDUSTRY: MFG. CEMENT
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Franklin Dayhoff
14. MOTHER'S MAIDEN NAME: Martha Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Patient (deceased) ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral metastases — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Carcinoma of Lung.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION: Inoperable Ca lung.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-8, 1949, *to* 1-10, 1950, *that I last saw the deceased alive on* 1-10, 1950, *and that death occurred at* 7^15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. F. Rheinhart Jr. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 13/50
24C. NAME OF CEMETERY OR CREMATORY: Rest Haven
24D. LOCATION (City, town, or county) (State): Hagerstown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Registrar
25. FUNERAL DIRECTOR: Loring Byers
ADDRESS: 5005 Pk Heights Ave

VS 150

49623

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-120
50 0255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 50 0255
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Janie Davis

2. DATE OF DEATH: Jan. 9th 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1023 Capstan Court
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: W. Va.
B. COUNTY: Randolph
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Onego
D. STREET ADDRESS (If rural, give location): "

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/5/1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Kessel
14. MOTHER'S MAIDEN NAME: Ellen (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: David Waldron
ADDRESS: 1023 Capstan Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Malnourishment. possible malignancy ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12. 25, 1949 to 1. 8, 1950, that I last saw the deceased alive on 1. 8, 1950, and that death occurred at 9 a m., from the causes and on the date stated above.

23A. SIGNATURE: K Summers M. D.
23B. ADDRESS: 1045 Pelham Ave
23C. DATE SIGNED: 1. 10. 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Rose Sons
ADDRESS: 1217 St. Paul St.

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-436

50 0256

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0256

Registered No.

1. NAME OF DECEASED (Type or Print): Harry Wilderson

2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1607 Union Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 13-08
D. STREET ADDRESS (If rural, give location): 1607 Union Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 6/11/1873
9. AGE (In years last birthday): 76
If Under 1 Year: Months: 6 Days: 28
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard Wilderson
14. MOTHER'S MAIDEN NAME: Wilhelmina Schwartz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-12-4498
17. INFORMANT: Margaret Benning
ADDRESS: 1607 Union Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congestive heart failure, acute	sudden
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Myocarditis	[illegible]
DUE TO		
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. 12, 1949 *to* Jan. 9, 1950, *that I last saw the deceased alive on* Jan. 9, 1950, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Reuben Hoffman M. D.
23B. ADDRESS: 846 W. 36th St.
23C. DATE SIGNED: Jan. 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible] for Williams
25. FUNERAL DIRECTOR: J. E. Cox Inc.
ADDRESS: 1207 St. Paul St.

VS 150

46051

93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

426

50 0257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 972

Registered No. 50 0257

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LORETTA GLASER N-968.0

2. DATE OF DEATH: January 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2738 Pennsylvania Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 1905
9. AGE (In years last birthday): 45
If Under 1 Year: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tom Buckley
14. MOTHER'S MAIDEN NAME: Not known ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Benjamine Glaser ADDRESS: 2738 Penn Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon monoxide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic alcoholism

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2738 Pennsylvania Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 9, 1950 ? a. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Three burners and oven on but unlit

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [X], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-50
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 151

163 H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3-400

50 0258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1

50 0258

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BELL, ARDIA

2. DATE OF DEATH: 1/9/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp. E.O.B
If not admitted to hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 2326 Stockton St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 2326 Stockton St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 65 yr. ago.
9. AGE (In years last birthday): 64
If Under 1 Year: Months | Days: Jan 21 | Hours | Min.: 1884

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: for self
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emanuel Bell
14. MOTHER'S MAIDEN NAME: Clara Drummond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jane Bell (wife)
ADDRESS: 2326 Stockton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident

DUE TO

(B) Hypertension

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9, 1949 *to* 1/9, 1949 *that I last saw the deceased alive on* 1/9, 1949, *and that death occurred at* 5:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Holmes M. O.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 12 1950
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Jas Brooks
ADDRESS: 1463 N. Carey St.

VS 150

33685

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-516

50 0259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0259

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FLORENCE BAKER JANVIER

2. DATE OF DEATH: Jan 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 253-00 Citronnelle
D. STREET ADDRESS (If rural, give location): 114 Oakdale Ave.

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 9-14 1872
9. AGE (In years last birthday): 77 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Baker
14. MOTHER'S MAIDEN NAME: Wilhelmina Durham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Emma Baker — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) BILATERAL PULMONARY EDEMA & EFFUSION

DUE TO

(C) HYPOSTATIC PNEUMONIA

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/6, 19[illegible], *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 12:25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: [illegible] Ave.
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-426

50 0260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

332

50 0260

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAX MILHISER

2. DATE OF DEATH: Jan.10, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 1632 N.Appleton St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02

D. STREET ADDRESS (If rural, give location): 1632 Appleton Street

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Oct 7,1888

9. AGE (In years last birthday): 61

If Under 1 Year: Months 3 Days 3 | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Asphalt

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Milhiser

14. MOTHER'S MAIDEN NAME: Rachel Poppenheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Carrie Milhiser

ADDRESS: 1632 Appelton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/5, 1947, *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 3^30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward S. Collins M. D.

23B. ADDRESS: 1847 W. North Ave

23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan.12,1950

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship

24D. LOCATION (City, town, or county) (State): Philadelphia Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: David Sondheim & Son

ADDRESS: DAVID SONDHEIM & SON 1902 Eutaw Place

VS 150

98898

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-524 50 0261

JL- 127312

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491

Registered No. 50 0261

1. NAME OF DECEASED (Type or Print): Robert Tinsley

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 12 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1631 Madison Ave. -17

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: Dec. 8, 1874
9. AGE (In years last birthday): 75 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business Man
10B. KIND OF BUSINESS OR INDUSTRY: Coal & wood
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? ✓
13. FATHER'S NAME: Mike Draper
14. MOTHER'S MAIDEN NAME: Liza Tinsley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): W. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4-49, 19__, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 19 50, *and that death occurred at* 4.30 am, *from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Cohen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 11, 1950
24C. NAME OF CEMETERY OR CREMATORY: Laurel Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Hartland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

13677

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 650

50 0262

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 50 0262

Registered No.

1. NAME OF DECEASED (Type or Print): Sterling A. Graham

2. DATE OF DEATH: Jan. 8/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3712 Cranston Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08
D. STREET ADDRESS (If rural, give location): 3712 Cranston Ave.

5. SEX: Male
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 17, 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Penn. R. R.
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Allen Graham
14. MOTHER'S MAIDEN NAME: Margaret------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Emma E. Graham, ADDRESS: 3712 Cranston Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 12, 1946, *to* Jan 8, 1950, *that I last saw the deceased alive on* Jan. 8, 1950, *and that death occurred at* 7.55 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Yaffe M. D.
23B. ADDRESS: 3101 W. Baltimore St.
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 12/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park, 3801 Frederick Rd
24D. LOCATION (City, town, or county) (State): Balto. 29 Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Harry A. Kuykendall
ADDRESS: 4101 Edmondson Ave.

VS 150

32247

Funeral for Williams, Mrs.

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H 420
50 0263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H 43 50 0263
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margie Hulse
2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. ~~mt~~. 24-1
D. STREET ADDRESS (If rural, give location): 1415 Andre St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 6, 1883
9. AGE (In years last birthday): 66 67
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bud Vickers
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Self
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1-7-50 to 1-9-50
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Cardiovascular Disease
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 7, 1950, *to* Jan 9, 1950, *that I last saw the deceased alive on* Jan 9, 1950, *and that death occurred at* 11 03 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jerome Pleet M. D.
23B. ADDRESS: 2300 Whittier Ave.
23C. DATE SIGNED: Jan 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Annapolis Blvd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Chas. F. Dell
ADDRESS: 1501 E Fort Ave.

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

M-620
50 0264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

331

50 0264
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE W. MYERS

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3805 Granada Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3805 Granada Ave.

15-10

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): 216-09-3361
8. DATE OF BIRTH: July 27, 1895
9. AGE (In years last birthday): 54 yrs.
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Metal Shop
10B. KIND OF BUSINESS OR INDUSTRY: Automobile Agency
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William D. Myers
14. MOTHER'S MAIDEN NAME: Jane Route

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-3361
17. INFORMANT: Mrs. Lillian N. Myers
ADDRESS: 3805 Granada Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage + paralysis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) Arteria sclerosis — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1950, *to* Jan 8, 1950, *that I last saw the deceased alive on* Jan 8, 1950, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter S. Tublett M. D.
23B. ADDRESS: 2220 Garrison Blvd
23C. DATE SIGNED: Jan 10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Lucretia Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150
33244

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H 525

Dr. Sawyer

50 0265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 0 50 0265

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maud E. Hanson

2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4000 Mayberry Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 77-05
D. STREET ADDRESS (If rural, give location): 4000 Mayberry Road

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: July 18, 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William N. Hanson
14. MOTHER'S MAIDEN NAME: Alice A.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Viola Hanson, 4000 Mayberry Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Coronary Occlusion	1 day
	DUE TO Arteriosclerotic Heart Disease	5 yrs.
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B)	
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Chr. Ulcerative Colitis	5 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 10, 1949, *to* Jan. 9, 1950, *that I last saw the deceased alive on* Jan. 8, 1950, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leroy Sawyer M. D.
23B. ADDRESS: 4808 Harford Rd
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Oaklawn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: [illegible] for [illegible], M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Rd.

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-314

Dr. Zimmerman 50 0266
2858 Harford Road

50 0266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katherine M. Stiefel

2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3111 White Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-44
D. STREET ADDRESS (If rural, give location): 3111 White Avenue

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Oct. 6, 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Tobias Stiefle
14. MOTHER'S MAIDEN NAME: Christina Wuertz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Carrie Stiefel
ADDRESS: 3111 White Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: April 1949
19B. MAJOR FINDINGS OF OPERATION: Cancer
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* Jan 9, 1950, *that I last saw the deceased alive on* Jan 9, 1950, *and that death occurred at* 7.30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. L. Zimmerman M. D.
23B. ADDRESS: 2858 Harford Rd
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1-11-50
REGISTRAR'S SIGNATURE: Lunsington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Road

VS 150

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50

G 635
50 0267

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 22 150 0267

Registered No.

1. NAME OF DECEASED (Type or Print): KATHERINE GARDNER (GARTNER)

2. DATE OF DEATH: Jan. 10 - 50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 135 E. West St.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 24-3
D. STREET ADDRESS (If rural, give location): 135 E. WEST ST.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: MARCH 30-1875
9. AGE (In years last birthday): 74 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: BERNARD GARDNER
14. MOTHER'S MAIDEN NAME: GERTRUDE MÜLLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: GEORGE GARDNER — ADDRESS: 135 E. WEST ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — 2 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic nephrosclerosis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1950 to Jan 10, 1950 that I last saw the deceased alive on Jan 10, 1950, and that death occurred at 8 P m., from the causes and on the date stated above.

23A. SIGNATURE: Isaac Miller M.D. M. D.
23B. ADDRESS: 1224 Cleveland ST
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Jan. 14-50
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BELAIR RD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 31 1950
REGISTRAR'S SIGNATURE: Emmitt Williams M.D.
25. FUNERAL DIRECTOR: Elizabeth Harle Inc
ADDRESS: 115 E. West St.

931

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-620
50 0268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0268

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude Brooks
2. DATE OF DEATH: 1/8/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1317 Madison Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Por-Wil-Ba Home
C. Length of stay in Baltimore: unk Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-8
D. STREET ADDRESS (If rural, give location): 111- Welcome alley

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: unk
9. AGE (In years last birthday): 78 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): unk
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unk
14. MOTHER'S MAIDEN NAME: unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elizabeth Williams ADDRESS: 1317 Madison Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Renal

DUE TO

(B) Disease - Hemiplegia 1 year

DUE TO

(C) Decubitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5 *, 19*50*, to* 1/8 *, 19*50*, that I last saw the deceased alive on* 1/7 *, 19*50*, and that death occurred at* 2:10 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: M. Jackson M. D.
23B. ADDRESS: 6000 Auburn Ave
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W. Baltimore St.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-552. CERTIFICATE CORRECTED 1-16-1950

50 0269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0269

BIRTH ND.

1. NAME DF DECEASED (Type or Print): Shemenski, Joseph F

2. DATE DF DEATH: Jan 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME DF HOSPITAL OR INSTITUTIDN (If not in hospital or institution, give street address or location): West Balto Gen Hosp
C. Length of stay in Baltimore: 10 Yrs. ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give town/ship): Baltimore Md. 1 Cantus Bay
D. STREET ADDRESS (If rural, give location): ~~1517 Lawrence St~~ 4326 Fairhaven 25-5

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDDWED, DIVORCED (Specify): M
8. DATE OF BIRTH: July 1 1881
9. AGE (In years last birthday): 68
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Night Watchman
10B. KIND DF BUSINESS OR INDUSTRY: MFG CHEMICAL
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ✓
14. MDTHER'S MAIDEN NAME: ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 221-05-2560
17. INFORMANT: ~~1517 Lawrence St~~ 4326 Fairhaven Frances Shemenski

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Portal Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES DR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CDNDITION LAST.

II
OTHER SIGNIFICANT CONDITIDNS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE DF OPERATIDN
19B. MAJDR FINDINGS OF DPERATIDN
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME DF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27, 19 49, *to* 1-9, 19 50 *that I last saw the deceased alive on* 1-9, 19 50, *and that death occurred at* 8:25 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marvin D. Davis M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 12 1950
24C. NAME OF CEMETERY OR CREMATDRY: Holy Cross
24D. LOCATION (City, town or county) (State): Harford Road and Benson Ave

DATE RECEIVED BY LDCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTDR: Charles W. Parkinkas
ADDRESS: Ritchie Highway, A.A.Co. Md. 703 McHenry St

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

m

G-620
50 0270

Gross.

50 0270

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Gross

2. DATE OF DEATH: Jan. 10. 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~Sellers Lutheran Home~~ Home for the Aged
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1200 Valley 10-01

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.
8. DATE OF BIRTH: March 30, 1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Gross
14. MOTHER'S MAIDEN NAME: Sarah Hope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Arterio-Sclerosis — 5 yrs
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 5, 1950, *to* Jan 10, 1950, *that I last saw the deceased alive on* Jan 9, 1950, *and that death occurred at* 8:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall M.D.
23B. ADDRESS: 1631 E. North Av
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 12, 1950
24C. NAME OF CEMETERY OR CREMATORY: Wm. Walters Memorial
24D. LOCATION (City, town, or county) (State): Parrisville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 11 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: Paul Weisfeld
ADDRESS: 906 Biddle St

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-525

BIRTH NO. 50 0271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

416

Registered No. 50 0271

1. NAME OF DECEASED (Type or Print): Dorothy Hinchman

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp
C. Length of stay in Baltimore: Yrs. 42 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1413 Linden Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: May 19, 1901
9. AGE (In years last birthday): 48
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Arthur S. Hecht
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Roy Granger, 1902 N. Washington St. ✓
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

(B) Rheumatic Ht. Dis. — 30

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-3, 1959 *to* 1-11, 1959 *that I last saw the deceased alive on* 1-11, 1950 *and that death occurred at* 265A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ruth Bleier M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Cuthington Williams M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., 1217 St. Paul St.
ADDRESS:

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R-300

50 0272
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 97 50 0272
Registered No.

1. NAME OF DECEASED (Type or Print): LILLIAN ANNA REED N-968.0

2. DATE OF DEATH: January 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04
D. STREET ADDRESS (If rural, give location): 24 S. Catherine Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED (Specify)~~: Widowed
8. DATE OF BIRTH: 7/8/1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months 6 Days 3
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Wm Kzach
14. MOTHER'S MAIDEN NAME: Charlotte Lemm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Melvina O'Loughlin ADDRESS: 24 S. Catherine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon monoxide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 24 S. Catherine Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 11, 1950 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Head in oven--on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. A. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm C. O'R Inc. ADDRESS: 1217 St. Paul St.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1949 - 13 - 11
1895 - 7 - 8
54 - 6 - 3

E-363

CERTIFICATE CORRECTED 1/12/50

BIRTH NO. 50 0273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0273

1. NAME OF DECEASED (Type or Print): Floyd F. Edwards -

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospt. -
C. Length of stay in Baltimore: 51 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 9-07
D. STREET ADDRESS (If rural, give location): 2623 Cecil Ave. —

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: (1899) May 13, 1893
9. AGE (In years last birthday): 5-7-52 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MFG. BEVERAGE
10B. KIND OF BUSINESS OR INDUSTRY: Salesman
11. BIRTHPLACE (State or foreign country): Baltimore, Md. -
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Victor H. Edwards
14. MOTHER'S MAIDEN NAME: Helena H. Menkens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-10-1949
17. INFORMANT: Mrs. Elizabeth Edwards, 2623 Cecil Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

ANTECEDENT CAUSES

(B) Hypertension — 5 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7, 1950, *to* 1-11, 1950, *that I last saw the deceased alive on* 1-11, 1950, *and that death occurred at* 10:25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Ford Schneeder M. D.
23B. ADDRESS: 1101 N. Milton Ave
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Christington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., 1217 St. Paul Street — ADDRESS

VS 150

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94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-652

50 0274

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 ✓

50 0274

Registered No.

1. NAME OF DECEASED (Type or Print): DAISY FRANK

2. DATE OF DEATH: 1/11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN. HOSP.
C. Length of stay in Baltimore: 71 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 15-07B
D. STREET ADDRESS (If rural, give location): 2109 Ellamont St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: May 2, 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jasper Newton McCauley
14. MOTHER'S MAIDEN NAME: Mary Holden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Donald M. Frank — ADDRESS: 2109 Ellamont St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

B. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

A. ARTERIOLOR NEPHROSCLEROSIS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1/ *, 19*50*, to* 1/11 *, 19*50*, that I last saw the deceased alive on* 1/10 *, 19*50*, and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. Solomon M. D.
23B. ADDRESS: WBGH
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. U. Meade and Son
ADDRESS: 505 N. Calvert St

VS 150

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131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-430

BIRTH NO. 50 0275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E-3 16.4

Registered No. 50 0275

1. NAME OF DECEASED (Type or Print): ELMER F. FLOYD

N-854.2

2. DATE OF DEATH: January 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 355 Savanah Avenue

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 14, 1908
9. AGE (In years last birthday): 41
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: Trucking Co.
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John F. Floyd
14. MOTHER'S MAIDEN NAME: Ann Hurst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 577-18-2047
17. INFORMANT: Doris A. Floyd
ADDRESS: 355 Savanah Ave. 21

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage - traumatic

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Mace and Savanah Avenues, Balto. County
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 8, 1949 8.45pm.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? auto - auto accident (driver)

22. *I certify that I took charge of the remains described above, held an* par. autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [X], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L. Rose M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13-50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Curtis Jon Williams, M.D.
25. FUNERAL DIRECTOR: F. R. HIRBERT & SON
ADDRESS: 1300 EUTAW PL. 17

VS 151

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E-B45

298.1

BIRTH NO. 50 0276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0276

1. NAME OF DECEASED (Type or Print): Louis D. Edelmann

2. DATE OF DEATH: 1/8/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: 28-04
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23
D. STREET ADDRESS (If rural, give location): 5008 Edmondson Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6/15/1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PROPRIETOR
10B. KIND OF BUSINESS OR INDUSTRY: Meat
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Edelman (dec'd)
14. MOTHER'S MAIDEN NAME: Florence Laney (dec'd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Helen Edelman
ADDRESS: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemoperitoneum — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Ruptured Spleen — 7-8 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1, 1950, *to* 1/8, 1950, *that I last saw the deceased alive on* 1/8, 1950, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wilfred J. Lirickos M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 12/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: C. P. Lippert & Son
ADDRESS: 1300 Eutaw St.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-314 HATFIELD

50 0277 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0277

1. NAME OF DECEASED (Type or Print): Margaret B. Hatfield

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3121 St Paul
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3121 St. Paul St.
C. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balloley
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ballo. 12-02
D. STREET ADDRESS (If rural, give location): 3121 St Paul St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 26 1870
9. AGE (In years last birthday): 79
If Under 1 Year: Months —, Days —; If Under 24 Hours: Hours —, Min. —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm H Brooks
14. MOTHER'S MAIDEN NAME: Mary Brooks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Berenice Hatfield
ADDRESS: Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Jan. 11, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 12 50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lentington Williams M.D.
25. FUNERAL DIRECTOR: Stewart & Manuel
ADDRESS: Balto.

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VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-162

50 0278

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 v

50 0278

Registered No.

1. NAME OF DECEASED (Type or Print): Bernard Shavrick

2. DATE OF DEATH: Jan 11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3453 Pk Hghts
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: 28 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 3453 Park Heights Ave
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): same 15-12

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 77 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reverend
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac
14. MOTHER'S MAIDEN NAME: Mary Levin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Son Joseph, ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrarteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

(B) with thrombosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from May, 1949 to Jan 11, 1950 that I last saw the deceased alive on Jan 6, 1950 and that death occurred at 4.20 p m., from the causes and on the date stated above.

23A. SIGNATURE: D.M. Bernard M. D.
23B. ADDRESS: 3455 Park Hights Ave
23C. DATE SIGNED: Jan 11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Shaarie Zion
24D. LOCATION (City, town, or county) (State): Rosedale

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 112 W. North Ave.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

652

50 0279
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0279

1. NAME OF DECEASED (Type or Print): Josephine Arrington 397441
2. DATE OF DEATH: JAN 8 - 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 311 W. Biddle St.

5. SEX: female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: 8-29-09
9. AGE (In years last birthday): 41
If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dayloous Taylor
14. MOTHER'S MAIDEN NAME: Elizabeth Christian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS ✓

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 410X

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): Chronic Rheumatic Heart Disease

DUE TO: Mitral stenosis

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28- *,* 1949 *to* 1-8- *,* 1950*, that I last saw the deceased alive on* 1-8- *,* 1950*, and that death occurred at* 5 05 *A.m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter Amos M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/8/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Francis A. Hemsley
ADDRESS: 578 W. Biddle St

VS 150

92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

28080

Letter in document file. 50-0279- 3/31/50

W-425

50 0280
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 4r

Registered No. 50 0280

1. NAME OF DECEASED (Type or Print): Ernest R. Wilson

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 333 Dolphin St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 333 Dolphin St.

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 18, 1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: RESTAURANT
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: George W. Wilson
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jeannette Nelson ADDRESS: 333 Dolphin St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cm. Cardio-renal vascular disease. — 2 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12. 14. *, 1949, to* 1. 10 *, 1950, that I last saw the deceased alive on* 1. 10 *, 1950, and that death occurred at* 7 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. L. Perry M. D.
23B. ADDRESS: 1420 C. Chase
23C. DATE SIGNED: 1. 11. 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Willenbrock
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley
ADDRESS: 578 W. Biddle St
0279

VS 150

72071

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

D-264

50 0281

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 50 0281

Registered No.

1. NAME OF DECEASED (Type or Print): Costanza Di Carlo

2. DATE OF DEATH: Jan. 9 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 2302 Ashland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DO

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-03

D. STREET ADDRESS (If rural, give location): 2302 Ashland Ave

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb.17 1881

9. AGE (In years last birthday): 68

If Under 1 Year: Months 10 Days 23

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Buttonholl maker

10B. KIND OF BUSINESS OR INDUSTRY: Mfg.Men's Clothing

11. BIRTHPLACE (State or foreign country): Prognola- Teramo- Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nicola Di Dominicis

14. MOTHER'S MAIDEN NAME: Scolastica

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): F

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-4554

17. INFORMANT: DOMINIC DI CARLO ADDRESS: 2302 ashland ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Pancreas

DUE TO

(B) Metastatic Carcinoma spleen & liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1948, *to* Jan 9, 1950, *that I last saw the deceased alive on* Jan 9, 1950, *and that death occurred at* 8 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. H. Goodman M. D.

23B. ADDRESS: 3460 E Belt St

23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: January 13/50

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.Bal.Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frank Della Rocca

ADDRESS: 322 S.High St.

VS 150

496 06

0280

469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-120

50 0282
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157 50 0282
Registered No.

1. NAME OF DECEASED (Type or Print): Carrie E. Livesay

2. DATE OF DEATH: 1/10/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 212 S. Gilmor St - 23
D. STREET ADDRESS (If rural, give location): Baltimore 19-04

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 6/21/1867
9. AGE (In years last birthday): 82
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Miles Gearhart
14. MOTHER'S MAIDEN NAME: Elizabeth Alberto

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Pearl Dolle (niece) ADDRESS: 5004 Kinds ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Head of Pancreas
DUE TO
(B) Generalized Carcinoma Osis
DUE TO
(C) Gastric Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9, 1950, *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 6:08 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mark E Hall, M. D.
23B. ADDRESS: U of Md Hosp
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-50
24C. NAME OF CEMETERY OR CREMATORY: National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo L. Beyer Jr ADDRESS: 1512 Hollins St. Balto. 23 Md

VS 150

0281

469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-350

50 0283

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0283

1. NAME OF DECEASED (Type or Print): SOPHIA ELIZABETH STONE

2. DATE OF DEATH: Jan. 9, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1824 Walbrook Ave.
60
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1824 Walbrook Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 4, 1869
9. AGE (In years last birthday): 80 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Henry Von Werder
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Louise A. Young — ADDRESS: 1824 Walbrook Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1440

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ch. Interstitial Nephritis — 1440

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 *, 1950, to* Jan. 9 *, 1950, that I last saw the deceased alive on* Jan 9 *, 1950, and that death occurred at* 9.15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Brown M. D.
23B. ADDRESS: 1663 W. North Ave.
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

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131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

L-520

50 0284

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

442

50 0284

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET LYNCH

2. DATE OF DEATH: 1-9-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1315 HILLMAN ST.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 9-09
D. STREET ADDRESS (If rural, give location): 1315 HILLMAN ST.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 12-7-1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM T. GROVES
14. MOTHER'S MAIDEN NAME: ? DOUGHERTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: MRS. E. STREB
ADDRESS: 701 ELMWOOD RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia - lobar — INTERVAL BETWEEN ONSET AND DEATH: 7 days.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Cardio-Vascular-Renal Disease — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 July, 1947, *to* 9 Jan, 1950, *that I last saw the deceased alive on* 9 Jan, 1950, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: S. Silverfield M. D.
23B. ADDRESS: 714 E. Preston
23C. DATE SIGNED: 10 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/13/1950
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Armington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Feiler Inc.
ADDRESS: Balto. Md.

VS 150

108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LILLENFELD, SAM
714 E. Preston St.
Sa. 5756

K-2-60

GM. 134236

50 0285
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0285
Registered No.

491

1. NAME OF DECEASED (Type or Print): Nathaniel Koger

2. DATE OF DEATH: 1-11-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Sparrows Point
D. STREET ADDRESS (If rural, give location): 2524 Sycamore Ave, Z 19

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 20 1949
9. AGE (In years last birthday): If Under 1 Year: Months 2½ Months; Days; If Under 24 Hours: Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: Mack Koger
14. MOTHER'S MAIDEN NAME: Dorothy Carrington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —

17. INFORMANT: Records
ADDRESS: Balto. City Hospital 4940 Eastern Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pe~~Bronchiolitis~~ l Thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Bronchiolitis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Possible Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-8-, 1950, *to* 1-11-, 1950, *that I last saw the deceased alive on* 1-11-, 1950, *and that death occurred at* 2.00 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: A. Rogers M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 1-11-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 12-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): A.A.Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: Robert T. Williams
ADDRESS: 1515 McElderry St

VS 150

0 2 8 4

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620
50 0286

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 0286
Registered No.

1. NAME OF DECEASED (Type or Print): Thomas S. Lee Horsey 154

2. DATE OF DEATH: 1/10/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp
C. Length of stay in Baltimore: 69 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: FRED.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore RURAL
D. STREET ADDRESS (If rural, give location): 6303 Holly Lane

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 14, 1870
9. AGE (Last birthday): 79 yr. | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Outerbridge Horsey
14. MOTHER'S MAIDEN NAME: Anna Carroll
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Peritonitis (acute purulent) — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Carcinoma of rectum with perforation — —
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fusiform aneurism abdominal aorta —
Generalized arteriosclerosis —

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: Fusiform aneurism, involving celiac
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/21, 1949 *to* 1/10, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 5 10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. Richard Frank M.D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 13 1950
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem.
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Christopher Williams M.D.
25. FUNERAL DIRECTOR: Harry W. Perkins & Sons Co.
ADDRESS: 4925 York Rd.

VS 150

46D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450.0

Registered No. 50 0287

BIRTH NO. 50 0287

1. NAME OF DECEASED (Type or Print): FANNIE TERHITZKY

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3705 Mortonia Road
C. Length of stay in Baltimore: 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-99
D. STREET ADDRESS (If rural, give location): 3705 Mortonia Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years if 1 or over): 88 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Borah
14. MOTHER'S MAIDEN NAME: Hadel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Isador Terrell — ADDRESS: 3705 Mortonia Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1 1949, to 1/11, 1950, that I last saw the deceased alive on 1/11, 1950, and that death occurred at 11:20 p m., from the causes and on the date stated above.

23A. SIGNATURE: Dr. H. S. Shelley M. D.
23B. ADDRESS: 2426 Eutaw Place
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Christina Hollingsworth
25. FUNERAL DIRECTOR: Jacob Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mrs Mullany
2426 Estate Dr
10 AM Me 2661

Mo 5024

B-660

50 0288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0288

BIRTH NO. 0288

1. NAME OF DECEASED (Type or Print): FANNIE BOHRER

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 113 No Broadway
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 113 No Broadway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 74 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Menusteen
14. MOTHER'S MAIDEN NAME: Rachael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Bohrer ADDRESS: 113 No Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease - enlarged heart grade IV decompensation
DUE TO
(B) Hypertensive CVD -
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 Mo.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/17, 1949, to 1/11, 1950 that I last saw the deceased alive on 1/11, 1950 and that death occurred at 10 m., from the causes and on the date stated above.

23A. SIGNATURE: Donald W. Winter M. D.
23B. ADDRESS: 3009 Evergreen Ave
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Dallo Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Keyrone
ADDRESS: 2100 Eutaw Pl

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Donald Hunter
3009 Evergreen Ave
Ha 6-3-07

Harford 5700

W-452

50 0289 134038

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

141

50 0289

Registered No.

1. NAME OF DECEASED (Type or Print): Levi Williams

2. DATE OF DEATH: 1-10-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 4416 Ivanhoe Ave. - ~~County~~

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 14, 1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman
10B. KIND OF BUSINESS OR INDUSTRY: Insurance Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nelson Williams
14. MOTHER'S MAIDEN NAME: Nancy Dickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Balto. City Hosp. Records — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Status post-operative carcinoma of tongue.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] yes [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-7-49, 19__, *to* Jan. 10, 1950, *that I last saw the deceased alive on* Jan. 10, 1950, *and that death occurred at* 5.30 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-50
24C. NAME OF CEMETERY OR CREMATORY: Pleasant Rest
24D. LOCATION (City, town, or county) (State): Lawson Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Laynes Sanders — ADDRESS: 1412 E. Preston St

VS 150
49680

452

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

151

50 0290

BIRTH NO. 49-28212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0 26 50 0290

Registered No.

1. NAME OF DECEASED (Type or Print): Helen Davenport

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-04
D. STREET ADDRESS (If rural, give location) 215 E. 23rd St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-22-09
9. AGE (In years last birthday): 40
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CLEM SMITH
14. MOTHER'S MAIDEN NAME: MITTIE ARVIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) ? Meningovascular syphilis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cesarean Section 12/30/49

over

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-30-, 1949, *to* Jan 8, 1950, *that I last saw the deceased alive on* Jan 8, 1950, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: William L. Hartmann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): B. C. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Minnie Lee Williams
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E. Preston St.

JAN 12 1950

VS 156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Birth - 49-28212 - 12/30/49

W-360

50 0291

BIRTH NO. 49-00965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0291

1. NAME OF DECEASED (Type or Print): EDWARD WEATHER — 334 X

2. DATE OF DEATH: January 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: I Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 3-02
D. STREET ADDRESS (If rural, give location): 1009 Granby Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: I/4/I949
9. AGE (In years last birthday): 1 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Freddie Weathers
14. MOTHER'S MAIDEN NAME: Mildred Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mildred Weathers — ADDRESS: I009 Granby St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Edema of brain

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: R. B. Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 11, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: I/I2/I950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Charles S. Williams, M.D.
25. FUNERAL DIRECTOR: Elroy C. Wilson — ADDRESS: I000 Brantly Ave

0 2 9 0

25970-11 83a

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-435

50 0292

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41

50 0292

Registered No.

1. NAME OF DECEASED (Type or Print): Henry Walden

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1313 E. Fayette St
C. Length of stay in Baltimore 5 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City 5-01
D. STREET ADDRESS (If rural, give location): 1313 E. Fayette St

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 19. 98
9. AGE (In years last birthday): 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fabrier
10B. KIND OF BUSINESS OR INDUSTRY: Va General
11. BIRTHPLACE (State or foreign country): Farmsville Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Walden
14. MOTHER'S MAIDEN NAME: Sallie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Sallie Jones
ADDRESS: 1313 E. Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 6 months.

DUE TO

ANTECEDENT CAUSES

(B) Malignant hypertension — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Nephrosis chronic. — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. *, 19*49 *to* Jan 8 *, 19*50*, that I last saw the deceased alive on* Jan 7 *, 19*50*, and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burwell M. D.
23B. ADDRESS: 1V1 Aisquith St.
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Timothy J. Williams, M.D.
25. FUNERAL DIRECTOR: Chas. O. Wilson
ADDRESS: 1010 Brunt Md

VS 150

98899

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

A-423

ALSTON

50 0293

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

Registered No. 50 0293

1. NAME OF DECEASED (Type or Print): Mary Alston

2. DATE OF DEATH: 1-8-50

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp

C. Length of stay in Baltimore: 27 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01
D. STREET ADDRESS (If rural, give location): 1453 Jefferson St.

5. SEX: F.

6. COLOR OR RACE: B.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Oct. 3. 1870

9. AGE (In years last birthday): 79. If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Smith

14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Step Daughter

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Silverchroid Hem.

DUE TO

(B) Hypertensive arteriosclerotic C.V. disease.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-8-50 19__, *to* 1-8-50 19__, *that I last saw the deceased alive on* 1-8-50 19__ *and that death occurred at* 5:45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert R. Hahn M. D.

23B. ADDRESS: University Hosp

23C. DATE SIGNED: 1-8-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-14-50

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State): Brooklyn A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson

ADDRESS: 1000 Brantley Ave

VS 150

0 2 9 3

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-430

50 0294

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0294

Registered No.

1. NAME OF DECEASED (Type or Print): William H. La Lotte

2. DATE OF DEATH: 1/11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 727 Carroll St.
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 727 Carroll St.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5/21/1868
9. AGE (in years last birthday): 81
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lamp Lighter
10B. KIND OF BUSINESS OR INDUSTRY: American Gas Lighting Co.
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter La Lotte
14. MOTHER'S MAIDEN NAME: Mary Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Katherine La Lotte
ADDRESS: 727 Carroll St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio Vascular Disease — 5 yr

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/10, 1949 *to* 1-11, 1950, *that I last saw the deceased alive on* 1/11, 1950, *and that death occurred at* 2 08 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph G. Lauckaitis M. D.
23B. ADDRESS: 679 Washington Blvd
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: St Peter's Cem
24D. LOCATION (City, town, or county) (State): 1300 Moreland Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Martin Tom Williams, M.D.
25. FUNERAL DIRECTOR: John J. Lowan & Son
ADDRESS: 901 Hollins St.

VS 150 49658

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0-542

50 0295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

Registered No. 50 0295

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 621 W. Saratoga

(c) Hospital or institution:

00

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County 4-02

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 621 W. SARATOGA ST (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Beulah Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-7296

4. Sex FEMAL

5. Color or race COLORED

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 25 1881

8. AGE: Years 68 Months Days If less than one day hr. min.

9. Birthplace MARTIN COUNTY - N.C. (Town, county, and state)

10. Usual Occupation HOTEL MAID

11. Industry or business

FATHER

12. Name PLAZE GODDARD

13. Birthplace

MOTHER

14. Maiden Name CATHEADA - ?

15. Birthplace

16 (a) Informant ERSEL DANIELS

(b) Address 814 EDMONDSON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-15-50 (month) (day) (year)

(c) Cemetery or crematory WILLIAMSTON

Location WILLIAMSTON N.C.

18 (a) Funeral director WILLIAM A. JACKSON

(b) Address 916 PENNA. AVE

19 (a) JAN 12 1950 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 50 19 , at 440a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 50 19 to Jan 10 50 19 , and that I last saw her alive on Jan 9 50 .

Immediate cause of death Cerebral Hemorrhage — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. R. Johnson M. D.

Address MED. ARTS BLD Date signed 1-10-50

830

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

N-240

50 0296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

154

50 0296

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE NAGEL (GEORGE NAGEL)

2. DATE OF DEATH: Jan 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSP
C. Length of stay in Baltimore: Yrs. Mos. Days — Lifer

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-03
D. STREET ADDRESS (If rural, give location): 3039 CHESTERFIELD AVE

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Dec 6 1876
9. AGE (In years last birthday): 73
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Matress maker.
10B. KIND OF BUSINESS OR INDUSTRY: International Bedding co.
11. BIRTHPLACE (State or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ludwig Nagel
14. MOTHER'S MAIDEN NAME: Margaret Link

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-03-8849
17. INFORMANT: Mrs. Anna L. Nagel — ADDRESS: 3039 Chesterfield Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma rectosigmoid colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

ANTECEDENT CAUSES

(B) Paralytic ileus — 3 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Shock — 6 hr

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: Jan 7, 1950
19B. MAJOR FINDINGS OF OPERATION: None - Transverse colostomy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 1950, *to* Jan 10, 1950 *that I last saw the deceased alive on* 2:00 PM, 19__, *and that death occurred at* 3:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Evan P English M. D.
23B. ADDRESS: Md. Gen'l Hosp
23C. DATE SIGNED: Jan 10

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150

496 IV

46D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-423

CERTIFICATE CORRECTED 1/20/50

50 0297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

450-1

Registered No. 50 0297

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES B. CLAXTON

2. DATE OF DEATH: January 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 535- Camel Street.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 535 Camel St.

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 26/08
9. AGE (In years last birthday): 41
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Gas + Elect. Co
11. BIRTHPLACE (State or foreign country): Wakebrauch W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Willie Claxton.
14. MOTHER'S MAIDEN NAME: Mollie Morton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): WORLD War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: MARION CLAXTON* DAUGHTER
ADDRESS: 2534 Penna AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene of left leg and right foot
~~XXXXX~~ DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lucille Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 - Druid Hill Ave.

VS 151

98854 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F 550 540 50 V 0298 (FAMIL)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0298

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FAMON, JAMES

2. DATE OF DEATH: 1/7/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 17-02
D. STREET ADDRESS (If rural, give location): 1017 Penna. Ave.

5. SEX: M
6. COLOR OR RACE: NEGRO
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: ? ? 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Edgewood, Md.
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel Brown
ADDRESS: 1017 Penna

MEDICAL CERTIFICATION

18. 592 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure

DUE TO

ANTECEDENT CAUSES

(B) Chronic Glomerulonephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

over

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31 *to* 1/7, 1950 *that I last saw the deceased alive on* 5 PM 1/6/50, 1950 *and that death occurred at* 2 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 Lancaster St.

VS 150 988 98

131 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

43109

Letter in document file. 50-0298 - 3/31/50

H-252

50 0299

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0299

Registered No.

1. NAME OF DECEASED (Type or Print): William H. Hawkins.

2. DATE OF DEATH: 1-10-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 133- Enow Alley.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (Rural, give location): 133- Enow Alley

5. SEX: M.
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: - -49
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Bowie Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Samuel Hawkins
14. MOTHER'S MAIDEN NAME: Christina Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Clarence N. Hawkins
ADDRESS: 1632

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
(B) ? — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(C) ? — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1949, *to* 10 Jan, 1950, *that I last saw the deceased alive on* 8 Jan, 1950 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burwell M. D.
23B. ADDRESS: 1V1 Arguile V
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: A. J. Halstead
ADDRESS: 918 - 13B Druid Hill ave.

VS 150

420 V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-263

50 0300
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44

50 0300
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mary E. Riechert

2. DATE OF DEATH: January 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4817 Windsor Mill Road
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 4817 Windsor Mill Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 28, 1874
9. AGE (In years last birthday): 75 yrs
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin Ritter
14. MOTHER'S MAIDEN NAME: Mary Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. Grace M. Davis
ADDRESS: 4817 Windsor Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Cardiovascular Disease — 4 years

19A. DATE OF OPERATION: No operation
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 27, 1947, *to* January 11, 1950, *that I last saw the deceased alive on* January 11, 1950, *and that death occurred at* 12.10A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joshua H. Arlinscost M. D.
23B. ADDRESS: 6419 Windsor Mill Road
23C. DATE SIGNED: Jan 11, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13, 1950
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. W. Lamoreau
ADDRESS: 4510 Liberty Heights Ave.

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50 0301

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X

50 0301

Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT N. CASSELL 4/90X 4/90X

2. DATE OF DEATH: 1/11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Md.
C. Length of stay in Baltimore: Yrs. Mos. Days 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): UpperCo
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1825
9. AGE (In years last birthday): 74 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Henry Cassell.
14. MOTHER'S MAIDEN NAME: Mary Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: H. H. Cassell. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic cardiovascular disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Congestive Heart Failure

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/6, 1950, *to* 1/11, 1950, *that I last saw the deceased alive on* 1/4, 1950, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mark E. Wolf Jr. M. D.
23B. ADDRESS: U of Md Hospital
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery
24D. LOCATION (City, town, or county) (State): Beallsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. L. Creager & Sons - Thurmont, Md.
ADDRESS:

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50 0302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Roehrer

2. DATE OF DEATH: Jan.IIth.,I950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Convalescent Home 4700 Harford Rd.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2438 E.Preston Street 8-3

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 26,I875
9. AGE (In years last birthday): 74 — If Under 1 Year: Months 9, Days I5; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore,Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Roehrer
14. MOTHER'S MAIDEN NAME: Barbara Baum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs.Emma Ensor--2438 E.Preston Street — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency. — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis, generalized. — INTERVAL BETWEEN ONSET AND DEATH: unknown

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertrophic Arthritis. — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Nov, 1948, *to* 10 Jan, 1950, *that I last saw the deceased alive on* 10 Jan, 1950, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Morgan Cochrane M. D.
23B. ADDRESS: 1616 N. Milton Ave
23C. DATE SIGNED: 1 V Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: I-I3-50
24C. NAME OF CEMETERY OR CREMATORY: St.Mathews Cemetery
24D. LOCATION (City, town, or county) (State): 6I00 O'Donnall St.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: George J.Ruth,Inc. — ADDRESS: --I735 Harford Avenue

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-614

50 0303

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X

50 0303

Registered No.

1. NAME OF DECEASED (Type or Print): ADAM COOPER WARFEL

162

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Park Drive & 31st St.
C. Length of stay in Baltimore: 57 ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton
D. STREET ADDRESS (If rural, give location): Silver Spring Road

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/26/91
9. AGE (In years last birthday): 58
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Warfel
14. MOTHER'S MAIDEN NAME: Lillian Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Records- US Marine Hospital, Balto, Md.
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiogenic carcinoma with metastases ~~Tumor involving~~ mediastinal lymph, mesenteric and retroperitonal nodes — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ---
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ---
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ---
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ---
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? ---

22. *I hereby certify that I attended the deceased from* Nov. 25, 1949, *to* Jan. 11, 1950, *that I last saw the deceased alive on* Jan. 11, 1950, *and that death occurred at* 10 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ray Brown M.D. - SA Surg USPHS Officer of Day, M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-50
24C. NAME OF CEMETERY OR CREMATORY: Ivywood Cem. Phila. Pa.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: John C. Milly Inc. 2435 E. Olney St
ADDRESS

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L-550

BIRTH NO. 50 0304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 50 0304

1. NAME OF DECEASED (Type or Print): FRANCES ELIZABETH LOHMANN 442

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Oklahoma
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tulsa
D. STREET ADDRESS (If rural, give location): 1743 S. Yorktown Avenue

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 14, 1920
9. AGE (In years last birthday): 29
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: Occ. Therapy
11. BIRTHPLACE (State or foreign country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry R. Lohmann
14. MOTHER'S MAIDEN NAME: Frances Eberle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Frances E. Lohmann
ADDRESS: Tulsa, Okla. 1743 S. Yorktown Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema, Acute
Cardiac Decompensation, Acute — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO Necrotizing Arteriolitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascularenal Dis., Malignant Type
Or DUE TO

(C) Chronic Glomerulonephritis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Secondary Anemia, Malnutrition

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-, 1950, *to* 1-12-, 1950, *that I last saw the deceased alive on* 1-12-, 19 50, *and that death occurred at* 4:50 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: W. A. Wiemann M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1/12/50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Crematory
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C-623

BIRTH NO. 50 0305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

391.1

Registered No. 50 0305

1. NAME OF DECEASED (Type or Print): GEORGE WILLIAM CARSTENS, Jr.

2. DATE OF DEATH: 1/10/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wm Balto General Hosp
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 15-07B
D. STREET ADDRESS (If rural, give location): 2301 N. Longwood St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 3, 1900
9. AGE (In years last birthday): 49 yrs. — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treasurer
10B. KIND OF BUSINESS OR INDUSTRY: Lumber Company
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George W. Carstens, Sr.
14. MOTHER'S MAIDEN NAME: Rose Ganz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Helen E. Carstens — ADDRESS: 2301 N. Longwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumococcal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 36 hr

DUE TO

ANTECEDENT CAUSES

(B) Chronic Otitis Media

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9/50, 19__, *to* 1/10/50, 19__, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 3 45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Shea M. D.
23B. ADDRESS: WBGH
23C. DATE SIGNED: 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Winfield Williams, M.D.
25. FUNERAL DIRECTOR: WM J TICKNER & SONS
ADDRESS: Balto., Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H 322

BIRTH NO. 50 0306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 Registered No. 50 0306

1. NAME OF DECEASED (Type or Print): Harry Hodges

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 609 Winans Way
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 609 Winans Way

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 27, 1868
9. AGE (In years last birthday): 81 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sec'y.
10B. KIND OF BUSINESS OR INDUSTRY: Fuel Company
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William J. Hodges
14. MOTHER'S MAIDEN NAME: Emma Cummings
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-18-3149
17. INFORMANT: Mrs. Clara L. Hodges ADDRESS: 609 Winans Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the pancreas with metastasis to liver.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary thrombosis, + arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Nov, 1949, to 10 Jan, 1950, that I last saw the deceased alive on 10 Jan, 1950, and that death occurred at 7 30 p m., from the causes and on the date stated above.

23A. SIGNATURE: Emil H. Hemming Jr. M. D.
23B. ADDRESS: 601 Winans Way
23C. DATE SIGNED: 12 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: W. J. TICKNER & SONS ADDRESS: Balto., Md.

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50 0307

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 2 2

50 0307

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS W. LUTZ

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1724 N. Appleton St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 1724 N. Appleton St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 11, 1874 1864
9. AGE (In years last birthday): 85 yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer (retired)
10B. KIND OF BUSINESS OR INDUSTRY: Own Grocery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Lutz
14. MOTHER'S MAIDEN NAME: Barbara Ann --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mr. Fuhrman W. Lutz
ADDRESS: 1724 N. Appleton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 1948, 19__, *to* Jan 11 1950, 19__, *that I last saw the deceased alive on* Jan 6 50, 19__, *and that death occurred at* 9 am *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1934 West Cor
23C. DATE SIGNED: Jan 12 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: WM. J. DICKNER & SONS
ADDRESS: Balto., Md.

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P-324

50 0308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 900.0

50 0308 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANCIS (FRANK) J. POETZEL — N-804.2

2. DATE OF DEATH 1/10/50

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTO, Md., INC.

C. Length of stay in Baltimore 47 Yrs. Mos. Days 42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO., Md. 26-09

D. STREET ADDRESS (If rural, give location) 805 S. EATON ST.

5. SEX M

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH JAN. 22, 1902

9. AGE (In years last birthday) 47

If Under 1 Year: Months Days

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROOM-SEWER

10B. KIND OF BUSINESS OR INDUSTRY ATL. S.W. BROOM CO.

11. BIRTHPLACE (State or foreign country) BALTO., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ANDREW C. POETZEL

14. MOTHER'S MAIDEN NAME ANNA A. KAPPAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 213-05-5211

17. INFORMANT JOSEPH POETZEL ADDRESS 807 S. FAGLEY ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma - Rt. side — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Fall down flight of stairs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

CERTIFICATION NOT ISSUED BY J. W. B. Fisher M.D. ASSISTANT MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Skull; Fractured clavicle

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) ACCIDENT

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) IN HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home - See above

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1/8/50 m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fell down flight of stairs (Slipped)

22. I hereby certify that I attended the deceased from 1/8, 1950 to 1/10, 1950, that I last saw the deceased alive on 1/9, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE Arthur I. Rudolph M. D.

23B. ADDRESS Sinai Hosp.

23C. DATE SIGNED 1/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 1-13-50.

24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM

24D. LOCATION (City, town, or county) (State) GERMAN HILL RD. BALTO. Co.

DATE RECEIVED BY LOCAL REGISTRAR JAN 12 1950

REGISTRAR'S SIGNATURE Lurington Williams M.D.

25. FUNERAL DIRECTOR Charles L. Geiler

ADDRESS 901 S. Conkling St.

49643

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-000

50 0309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0309

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Susie Lee

2. DATE OF DEATH: JAN 11 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1615 McCulloh St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 4-12-04
9. AGE (In years last birthday): 46 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Days work
11. BIRTHPLACE (State or foreign country): Graysburg, N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sherman Lee
14. MOTHER'S MAIDEN NAME: Phyllis Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerosis reparo sclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Hypertensive Cardiovascular Dis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-7- 1950, *to* 1-11 1950, *that I last saw the deceased alive on* 1-11- 1950, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter Arons M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Diamond Grove
24D. LOCATION (City, town, or county) (State): Emporia, Va

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Nimrington Williams, M.D.
25. FUNERAL DIRECTOR: Halland Funeral Home — ADDRESS: 1631 David Hill Ave.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0310 49-23944

Registered No. 50 0310

1. NAME OF DECEASED (Type or Print): McCABE, DONALD 754.4

2. DATE OF DEATH: 1/11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: 2 ~~Yrs.~~ Mos. ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 27-16
D. STREET ADDRESS (If rural, give location): 2421 COLD SPRING LANE

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: Nov 7, 1949
9. AGE (In years last birthday): If Under 1 Year: Months 2, Days 4; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LOUIS McCABE
14. MOTHER'S MAIDEN NAME: RUTH COOLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis McCabe — ADDRESS: 2421 Cold Spring Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGENITAL HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/5, 1950, *to* 1/11, 1950, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 7:40 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Baelman M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge
24D. LOCATION (City, town, or county) (State): Dorsey Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lucius Williams, M.D.
26. FUNERAL DIRECTOR: Harry G. Witzke
ADDRESS: 4101 Edmondson Ave

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-460

BIRTH NO. 50 0311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0311

1. NAME OF DECEASED (Type or Print): Samuel Walter Taylor

2. DATE OF DEATH: Jan. 10/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 624 N. Hilton St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 624 N. Hilton St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 19, 1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Slaysman & Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Taylor
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary A. Taylor, 624 N. Hilton St. — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

(B) Arteriosclerosis (Senile) — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Jan 11, 1947 *to* Jan 10, 1950, *that I last saw the deceased alive on* Jan 10, 1950, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. A. Lally M. D.
23B. ADDRESS: 3517 Edmondson
23C. DATE SIGNED: Jan 11 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Pk.
24D. LOCATION (City, town, or county), (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Harrington Milnor, M.D.
25. FUNERAL DIRECTOR: Harry T. Pitts — ADDRESS: 4101 Edmondson Ave.

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-460
562 JL-75832
50 0312

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0312

1. NAME OF DECEASED (Type or Print): Peter Keller (Zanyrcazskiy)

2. DATE OF DEATH: 1-10-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 59 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 427 S. Dallas St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: Dec. 9, 1885
9. AGE (In years last birthday): 64 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TANERN REEPER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Keller (Zanyrcazskiy)
14. MOTHER'S MAIDEN NAME: Helen ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic Insufficiency

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Leutic Heart Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Leutic Aortic Aneurysm

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-3-42, 19__, *to* Jan. 10, 1950, *that I last saw the deceased alive on* Jan. 10, 1950, *and that death occurred at* 12.40 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: B. L. Rosen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Jan. 14. 1950.
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Lucington Williams, M.D.
25. FUNERAL DIRECTOR: Wendell J. Lippel
ADDRESS: 3125 Highland Ave

VS 150

0311

(N 6) 1

301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-350

50 0313

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0313

1. NAME OF DECEASED (Type or Print): Sallie Madden

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2520 Greenmount Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Southern Home
C. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2520 Greenmount Avenue

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: May 22, 1863
9. AGE (In years last birthday): 86 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: David Ford
14. MOTHER'S MAIDEN NAME: Hannah Brice
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records, Southern Home — ADDRESS: 2520 GreenmountAve

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

(B) arterio Sclerosis — 2 yrs

DUE TO

(C) old age.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* Jan. 11, 1950, *that I last saw the deceased alive on* Jan 10, 1950, *and that death occurred at* 1 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Blake MD M. D.
23B. ADDRESS: Medical Arts Bldg.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13, 1950
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 12 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. — ADDRESS: 1900 Eutaw Pl.
JOHN O. Mitchell

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

450

50 0314
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0314

1. NAME OF DECEASED (Type or Print): Thomas Leslie Mallonee
2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1400 N. Lexington St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aged Women's and Aged Men's Homes
C. Length of stay in Baltimore: Yrs. 70 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Butler
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: April 3 1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months 8 Days 8
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Worker
10B. KIND OF BUSINESS OR INDUSTRY: Electric Resistance
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas H. Mallonee
14. MOTHER'S MAIDEN NAME: Catherine A. Suter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): N (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-18-3224
17. INFORMANT: L. H. Read ADDRESS: 1400 N. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerotic Heart Disease — Years

DUE TO

(C) Carcinoma Colon — Months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: March 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Colon
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1949, *to* Jan. 11, 1950 *that I last saw the deceased alive on* Jan 10, 1950, *and that death occurred at* 12-01 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leland Edward Day M. D.
23B. ADDRESS: 4-E-33rd St
23C. DATE SIGNED: Jan. 12, 1950

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town or county) (State): Cockeysville Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Lucretia Williams
25. FUNERAL DIRECTOR: Mahoney & Son
ADDRESS: 1217 E. Pratt St

VS 150

496 37

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0315 — Registered No. 50 0315

1. NAME OF DECEASED (Type or Print): Clarence Eugene Tarman 154

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.M.H.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore-12, Md.
D. STREET ADDRESS (If rural, give location): 7005 Copeleigh

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5-28-1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None DRAFTSMAN
10B. KIND OF BUSINESS OR INDUSTRY: SCIENTIFIC INSTRUMENTS
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Thomas Tarman
14. MOTHER'S MAIDEN NAME: Elizabeth Wyman.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Self — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma rectosigmoid
DUE TO
(B) with metastasis to
DUE TO
(C) liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29 1949 *to* 1-12 1950, *that I last saw the deceased alive on* 1-12 1950 *and that death occurred at* 9:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Marshall Clarke M.D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/50
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: W. E. Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 50
V6 V35

46D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

L 263

50 0316

50 0316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-00249

1. NAME OF DECEASED (Type or Print): Baby Girl Dockard 760.5

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. 26 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Owings Mills
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1-6-50
9. AGE (In years last birthday): If Under 1 Year: Months: Days: 1 Hours: Min.: If Under 24 Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James E. Dockard
14. MOTHER'S MAIDEN NAME: Mary Jane Moser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) atelectasis & cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 40½ hrs

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6, 1950, *to* 1-7, 1950, *that I last saw the deceased alive on* 1-7, 1950, *and that death occurred at* 7 45 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: James P. Elkins M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JAN 10 1950

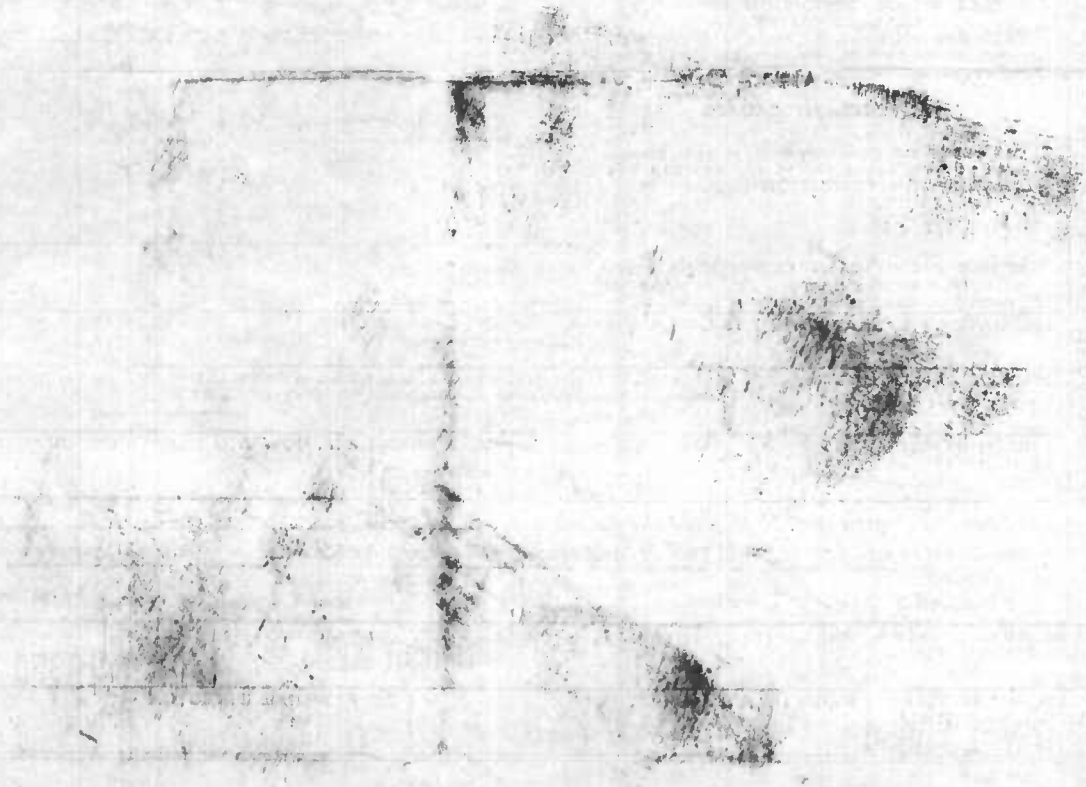
DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



C-223

50 0317

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0317

1. NAME OF DECEASED (Type or Print): Nalinda Chichester

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 N. Pearl St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 212 N. Pearl St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept. 30, 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Laurence Wilbert
14. MOTHER'S MAIDEN NAME: Beuna ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Chichester — ADDRESS: 212 N. Pearl St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 mo.

DUE TO

(B) + Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2 1950 *to* 1/11 1950, *that I last saw the deceased alive on* 1/11 1950, *and that death occurred at* 1:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dan Franklin M. D.
23B. ADDRESS: 1212 W See
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Culpeper, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley — ADDRESS: 578 W. Biddle St.

0310

VS 150

131 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69.5

BIRTH NO. 50 0318 - B.C. 50-00388

Registered No. 50 0318

1. NAME OF DECEASED (Type or Print): Baby Boy White (Twin)

2. DATE OF DEATH: Jan. 8, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): 730 Deepdene Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 1-6-50
9. AGE (In years last birthday) — If Under 1 Year: Months / Days: 2 — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C) Toxemia of Pregnancy

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 19 50 *to* Jan 8, 19 50 *that I last saw the deceased alive on* Jan 8, 19 50 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: James L. Gamble Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

Hospital Disposal

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-520 B.C. 50-00 387 (465403)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

776

BIRTH NO. 50 0319

Registered No. 50 0319

1. NAME OF DECEASED (Type or Print): Baby Girl Downs

2. DATE OF DEATH: January 6, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
c. Length of stay in Baltimore: – (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shady Side
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: January 6, 1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: 2 Min.: 26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Downs
14. MOTHER'S MAIDEN NAME: Shirley Turner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 2 26/60 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 6, 1950 *to* January 6, 1950, *that I last saw the deceased alive on* January 6, 1950, *and that death occurred at* 1:51P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: William L. Hartmann M.D.
23B. ADDRESS: 601 N. Broadway
23C. DATE SIGNED: January 9, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hop Bufonal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

0318

VS 150

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-200

50 0320

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0320

151

1. NAME OF DECEASED (Type or Print): FRANCIS JOHN HAYES

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore (Yrs. Mos. Days): ?

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NY
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 77 St. Marks Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: 3/19/03
9. AGE (In years last birthday): 46
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wiper
10B. KIND OF BUSINESS OR INDUSTRY: Seafarer
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John J. Hayes
14. MOTHER'S MAIDEN NAME: Lottie E. Lowery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 055-01-7850
17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma cardiac portion of stomach — Since April '49

DUE TO

(B) Metastatic to lymph nodes, liver, bone — Since April '49

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 26, 1949, *to* Jan. 10, 1950, *that I last saw the deceased alive on* Jan. 10, 1950, *and that death occurred at* 6:10A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clarence A. Ulat M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 1-12-50
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Bushlow & Lowman

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
FUNERAL DIRECTOR: Earl B. Wolverton
ADDRESS: 403 E. 25th St. Md.

VS 150

46251 46B Earl B. Wolverton 403 E. 25th St

P-643

50 0321

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0321

1. NAME OF DECEASED (Type or Print): Henry L. B. Parlett Hrol

2. DATE OF DEATH: 1/11/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Upperco
D. STREET ADDRESS (If rural, give location): Falls Road; White House

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 15, 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business Man
10B. KIND OF BUSINESS OR INDUSTRY: Retail Store
11. BIRTHPLACE (State or foreign country): Towson Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert W. Jackson Parlett
14. MOTHER'S MAIDEN NAME: May C. Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): First world war
16. SOCIAL SECURITY NO.
17. INFORMANT: Daughter — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: approx. 2 hr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11/, 1950, *to* 1/11/[redacted], 1950, *that I last saw the deceased alive on* 1/11, 1950, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Homer W. May M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13, 1950
24C. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Lemington Hollinger, M.D.
25. FUNERAL DIRECTOR: Joseph Burns' Sons, Towson, Md. — ADDRESS

VS No. 31014

Body released to hospital by [illegible] Funeral Dir. [illegible] at hospital

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-565

50 0322

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 Registered No.

50 0322

1. NAME OF DECEASED (Type or Print): Mary E Zimmerman

2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 2022 E Lanvale St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): no

C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 8-06

D. STREET ADDRESS (If rural, give location): 2022 E Lanvale St Balto 13 Md

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 12, 1879

9. AGE (In years last birthday): 70 | If Under 1 Year: Months 7 Days 0 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Corrigan Ireland

14. MOTHER'S MAIDEN NAME: Mary Brady Ireland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr James H Zimmerman ADDRESS: 2022 E Lanvale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast with metastases — INTERVAL BETWEEN ONSET AND DEATH: 20 months

DUE TO

(B) Bronchopneumonia — 12 hours.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1949, *to* Jan. 12, 1950, *that I last saw the deceased alive on* Jan 12, 1950, *and that death occurred at* 2:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: G. Karl Grossman M. D.

23B. ADDRESS: 1212 N. Patterson Park Ave

23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 16, 1949

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery

24D. LOCATION (City, town, or county) (State): Windsor Hill Road Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Albert L Nitz Jr

ADDRESS: 1606 N Chester St

VS 150

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-530

50 0323

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443 Registered No. 50 0323

1. NAME OF DECEASED (Type or Print): Jessie Smith.

2. DATE OF DEATH: Jan. 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4 S. Amity St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 4 S. Amity St.

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Jan. 5, 1866
9. AGE (In years last birthday): 84
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pittsburg, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Smith. ADDRESS: 4 S. Amity St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

(B) Hypertension

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* Jan 10, 1950, *that I last saw the deceased alive on* Jan 7, 1950, *and that death occurred at* 12:00 h m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Wallace Sherrington M. D.
23B. ADDRESS: 201 N Carey St.
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs. Kate R. Williams
ADDRESS: 392 N. Schroeder

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P-640

50 0324
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0324

1. NAME OF DECEASED (Type or Print): Robert Parrill — 754.0

2. DATE OF DEATH: January 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days: 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Keyser
D. STREET ADDRESS (If rural, give location): Route #2

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-18-32
9. AGE (In years last birthday): 17 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wade H. Parrill
14. MOTHER'S MAIDEN NAME: Mae Trentle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Embolus, left internal carotid artery — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs.
DUE TO
(B) Tetralogy of Fallot congenital
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/11/50
19B. MAJOR FINDINGS OF OPERATION: Tetralogy of Fallot
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10, 1950, *to* 1-12, 1950, *that I last saw the deceased alive on* 1-12, 1950, *and that death occurred at* 6:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard T. Kelly Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Cabin Run
24D. LOCATION (City, town, or county) (State): Keyser W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wilson & Son Inc
ADDRESS: 1217 St Paul St

VS 150

157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-653

Werneth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 r. 1

BIRTH NO. 50 0325

Registered No. 50 0325

1. NAME OF DECEASED (Type or Print): Mary W Werneth

2. DATE OF DEATH: 1/12/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1314 Aisquith St.
C. Length of stay in Baltimore: 68 Yrs. 11 Mos. 11 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9-09
D. STREET ADDRESS (If rural, give location): 1314 Aisquith St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 1. 1881
9. AGE (In years last birthday): 68
If Under 1 Year: Months 11, Days 11
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Matthew M. Mc Ennaney
14. MOTHER'S MAIDEN NAME: Mary Baltimore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Wm J. Werneth
ADDRESS: 1314 Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Jan 16 1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Elmer W. Conklin
ADDRESS: 924 E Eager St.

VS 151

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V-052

50 0326

BIRTH NO. 50-00977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X

Registered No. 50 0326

1. NAME OF DECEASED (Type or Print): Baby Girl Vernago 325.4

2. DATE OF DEATH: Jan 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen. Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days 46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto #14 Rural
D. STREET ADDRESS (If rural, give location): 7807 Old Harford Rd

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1/12/50
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: 1 Min.: 17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Joseph Vernago
14. MOTHER'S MAIDEN NAME: Elizabeth Ilene Warns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Unknown

DUE TO

(B) Baby had a Mongaloid face

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/12/50, 19__, *to* 1/12/50, 19__, *that I last saw the deceased alive on* 1/12/50, 19__, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thos. R. Ebbutson M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 13, 1950
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Pk
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edwin W. Conklin
ADDRESS: 924 E. Eager St.

VS 150

0325

84a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-124

BIRTH NO. 50 0327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.1 Registered No. 50 0327

1. NAME OF DECEASED (Type or Print): MARY J. LaPaglia

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1124 PROCTOR ST.

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 10-01

D. STREET ADDRESS (If rural, give location): 1124 PROCTOR ST.

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 2, 1887

9. AGE (In years last birthday): 72

If Under 1 Year: Months: 11 Days: 9

If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10B. KIND OF BUSINESS OR INDUSTRY: AT Home

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PETRO BONNANO

14. MOTHER'S MAIDEN NAME: MARY JERMINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Carmelo LaPagalia ADDRESS: 1124 Proctor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic Cardio-Vascular Renal Disease — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/10, 1950, *to* 1/11, 1950, *that I last saw the deceased alive on* 1/11, 1950, *and that death occurred at* 2 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Meyer L. Blum MD M. D.

23B. ADDRESS: 1115 N. Calvert St

23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY: St Vincent Cemetery

24D. LOCATION (City, town, or county) (State): BALTIMORE Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Elmer H. Conklin

ADDRESS: 924 E. Eager St

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. J. S Blum
1115 N. Calvert St.

250

50 0328
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20.0

50 0328
Registered No.

1. NAME OF DECEASED (Type or Print): HARRY F. DISNEY

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: --
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03
D. STREET ADDRESS (If rural, give location): 2800 East Chase Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: March 17, 1888
9. AGE (In years last birthday): 61 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Mechanic~~ MAINTENANCE MAN ~~Retired~~
10B. KIND OF BUSINESS OR INDUSTRY: P.O.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dennis Disney
14. MOTHER'S MAIDEN NAME: Mary Deaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknwn. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Frieda Vickers, 2800 E. Chase St. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 min.

DUE TO

ANTECEDENT CAUSES

(B) Myocardial Infarction — 18 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Coronary Occlusion
Arteriosclerotic Heart Disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary Edema
Congestive Heart Failure

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4-, 1950, *to* 1-12-, 1950, *that I last saw the deceased alive on* 1-12-, 1950, *and that death occurred at* 10:45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Wiesmann M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 16/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulman Funeral Home
ADDRESS: 2008 Aisquith

VS 150

33695 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-200

50 0329
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

50 0329
Registered No.

1. NAME OF DECEASED (Type or Print): Jacob Bach Jr (Jacob J. Bach)

2. DATE OF DEATH: 1/11/50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 15-06
D. STREET ADDRESS (If rural, give location): 1603 N. Longwood St. #16.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married.
8. DATE OF BIRTH: 4/21/93
9. AGE (In years last birthday): 56 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10B. KIND OF BUSINESS OR INDUSTRY: Umbrella Mfg.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Bach.
14. MOTHER'S MAIDEN NAME: Theakla Brunner Germany.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown.
17. INFORMANT: Elizabeth M. Bach Wife — ADDRESS: 1603 N. Longwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive heart failure;
~~DUE TO~~
(B) Uremia c̄ nephrolithiasis.
~~DUE TO~~
(C) acidosis; carcinomatosis originating in the bladder.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11/50, 19__, *to* 1/11/50, 19__, *that I last saw the deceased alive on* 1/11/50, 1950, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. A. Abraham, M.D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 1/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Roll & J. M. Walters
ADDRESS: Pratt & Stricker

VS 150
49637

52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-200

50 0330

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4200

50 0330 Registered No.

1. NAME OF DECEASED (Type or Print): Leo R. Wise

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
42
C. Length of stay in Baltimore: 11 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 3322 Auchentoroley Terrace

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 1, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hat Maker Factory
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Samuel Wise
14. MOTHER'S MAIDEN NAME: Sophie Stern

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John M Wise
ADDRESS: 5300 Haddon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASHD c Myocardial Infarction & Ruptured Myocardium

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
Dr. John R. Davis
B B Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-12, 1950 *to* 1-12, 1950 *that I last saw the deceased alive on* DOA, 19___ *and that death occurred at* 1350 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Kotz M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 13, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

496 03

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-500

50 0331

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0331

1. NAME OF DECEASED (Type or Print): David Kahn

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 3411 W. Rogers Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1907
9. AGE (In years last birthday): 42 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Propreiter
10B. KIND OF BUSINESS OR INDUSTRY: Bicycle Store
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Nathan Kahn
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Hannah Kahn
ADDRESS: 3411 West Rogers Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Decompensation

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary occlusion - coronary heart disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Mesenteric Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-6-50
19B. MAJOR FINDINGS OF OPERATION: Mesenteric Thrombosis; infarct Terminal ileum
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-5, 1950, to 1-12, 1950, that I last saw the deceased alive on 1-12, 1950, and that death occurred at 10:45 p m., from the causes and on the date stated above.

23A. SIGNATURE: Fred R. McClement Jr. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-50
24C. NAME OF CEMETERY OR CREMATORY: Brai Israel.
24D. LOCATION (City, town, or county) (State): Southern ave. Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Hillman, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros.
ADDRESS: 1124-26 West North Avenue

VS 150

15678

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

512

50 0332
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

Registered No. 50 0332

1. NAME OF DECEASED (Type or Print): Lucy Senft Leimbach

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days): Life time

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore CANTERBURY + 39th St
D. STREET ADDRESS (If rural, give location): Ambassador Apartments 12-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 7, 1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Senft
14. MOTHER'S MAIDEN NAME: Alreda Zepp.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Walter G. Leimbach
ADDRESS: Ambassador Apts

MEDICAL CERTIFICATION

18. CAUSES OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ?? Pulmonary embolus — 10 mo.
DUE TO
(B) Hypertensive H.D. — 5 yrs
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic phlebitis, left leg. 1 wk.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1950, *to* 1-12, 1950, *that I last saw the deceased alive on* 1-12, 1950, *and that death occurred at* 1:50 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Merrill F. Nelson M.D.
23B. ADDRESS: Union Mem. Hosp.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W- 420

50 0333

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0333 Registered No.

1. NAME OF DECEASED (Type or Print): George Columbus. Willis, Sr.

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
C. Length of stay in Baltimore: Yrs. 44 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: ~~606 E. 41st. Street~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City #18 9-01
D. STREET ADDRESS (If rural, give location): 606 E. 41st Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7-14-1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Boat Pilot
10B. KIND OF BUSINESS OR INDUSTRY: Steamship Transportation
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Christopher C. Willis
14. MOTHER'S MAIDEN NAME: Virginia Rouse
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes — (If yes, give war or dates of service): World War No 1
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mr. G. C. Willis, Jr. — ADDRESS: 820 N. 7th St. Columbia, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis of brain with Tuberculous meningitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary Tuberculosis with Tuberculosis of Mediastinal Lymph Nodes

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20, 1949 *to* 1-11, 1950, *that I last saw the deceased alive on* 1-11, 1950, *and that death occurred at* 10:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Frank Supplee, III M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: Jan 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Mausoleum
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

13051

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-355

50 0334

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 823.0

Registered No. 50 0334

1. NAME OF DECEASED (Type or Print): EDWARD MARSHALL REDMOND

N-991

2. DATE OF DEATH: January 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2910 W. North Avenue

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 1, 1917
9. AGE (In years last birthday): 32
If Under 1 Year: Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Road Contractors
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Edward M. Redmond, Sr.
14. MOTHER'S MAIDEN NAME: Elizabeth M. Singer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Elizabeth M. Redmond
ADDRESS: Hampstead, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture of left ankle
Dislocation of right shoulder

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Druid Park Drive near Greenspring Ave. 15/12
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 11, 1950 3.30p.m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Oil truck into ravine (Pinned in truck cab) (driver)

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [X], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L. Virgin M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Baltimore, Md

VS 151

420 V9

170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-623

MS--134526

50 0335

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

576

Registered No. 50 0335

1. NAME OF DECEASED (Type or Print): Sallie Sally A Wright

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 26 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1351 Mosher Street--Zone 17

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 1, 1879
9. AGE (In years last birthday): 70 ?
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Private Families
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Deceased)
14. MOTHER'S MAIDEN NAME: (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Peritonitis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28-, 1949, *to* 1-12-, 1950 *that I last saw the deceased alive on* 1-12-, 1950 *and that death occurred at* 7:35 AM *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Logan M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: THE CHARLES R. LAW MORTUARY
ADDRESS: 802-04 MADISON AVENUE BALTIMORE 1, MD.

VS 150

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931

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-325

50 0336

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

31 3

50 0336

Registered No.

1. NAME OF DECEASED (Type or Print): Walter M. Atkinson Sr.

2. DATE OF DEATH: January 10, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5330 Liberty Heights
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40
C. Length of stay in Baltimore: Yrs. Mos. Days — Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 5330 Liberty Heights Avenue.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Maryland, 28-01
D. STREET ADDRESS (If rural, give location): 5330 Liberty Heights Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 8, 1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months 6, Days 2 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter
10B. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? Baltimore
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Mary Alice Whitworth
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Walter M. Atkinson Jr. ADDRESS: 5330 Liberty Heights

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Bronchio - Pneumonia — 24 hours

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) - Generalized Arteriosclerosis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 9th, 1950 *to* Jan. 10, 1950, *that I last saw the deceased alive on* Jan. 10, 1950, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul L. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore -- Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Mamie C. Syfer
ADDRESS: 1600 W. North Ave

VS 150

34049

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-300
50 0337

50 0337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALEXANDER BUTT 5702

2. DATE OF DEATH: 1/13/50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Church Home + Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH Home + Hospital.
35
C. Length of stay in Baltimore 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Dundalk
B. COUNTY Baltimore
C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 50 Shipway St. Dundalk.

5. SEX: M.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: Dec 12-1866.
9. AGE (In years last birthday): 83 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Cafeteria Operator
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: BUTT Hoel; Fairfield Sr.
14. MOTHER'S MAIDEN NAME: RIDDICK Susan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): unknown.
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Lydia Butt, ADDRESS: 50 Shipways Dundalk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B) Mesenteric thrombosis.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO with perforation of Ileum.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/29/49.
19B. MAJOR FINDINGS OF OPERATION: Gangrenous Gall Bladder.
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29, 1950, *to* Jan 12, 1950, *that I last saw the deceased alive on* Jan 11, 1950, *and that death occurred at* 3 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: Rich Moore M. D.
23B. ADDRESS: Church Home + Hospital
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: Oakes Grove Cemetery
24D. LOCATION (City, town, or county) (State): Portsmouth, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Roland L. Fisher
ADDRESS: 1112 Dundalk Ave

VS 150

127B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W 630
50 0338

CERTIFICATE CORRECTED 1-17-1950

50 0338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hattie Ward (Hattie)

2. DATE OF DEATH: 1/10/50

3. PLACE OF DEATH: A. Baltimore City, Maryland 223 W. Hennrietta St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

C. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 223 W. Henrietta Street 23-1

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 10/10/86
9. AGE (In years last birthday): 63 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Johnson
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: William [redacted]ard
ADDRESS: 223 W Hennrietta St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 y

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-21, 1949 *to* 1-10, 1950 *that I last saw the deceased alive on* 1-8, 1950 *and that death occurred at* 1200 *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Atwell Jones M.D.
23B. ADDRESS: 504 Hollins St
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Ct
24D. LOCATION (City, town, or county) (State): A.A.Co., Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Lutherville Maryland
25. FUNERAL DIRECTOR: J. B. Brownlow
ADDRESS: 108 W. Montgomery

VS 150

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-550

50 0339

50 0339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

175

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Schumann, Marie

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): 41 St. Joseph's
C. Length of stay in Baltimore: 46 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2811 E. Chase St. 8-3

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 15, 1898
9. AGE (In years last birthday): 51
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwfe.
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Kovanda
14. MOTHER'S MAIDEN NAME: Elizabeth (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry O. Schumann
ADDRESS: 2811 E. Chase St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized abdominal carcinoma

DUE TO

(B) Carcinoma of ovaries

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: Dec. 2, 1949
19B. MAJOR FINDINGS OF OPERATION: Abdominal carcinomatosis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 21, 1949 *to* Jan. 11, 1950 *that I last saw the deceased alive on* Jan. 11, 1950, *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jos. Joseph Krejci M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Hill Cem.
24D. LOCATION (City, town, or county) (State): Horner's Lane, Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Lucille Williams M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-452

50 JL- 134496
50 0340
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

401.1

50 0340
Registered No.

1. NAME OF DECEASED (Type or Print): Obera Williams

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
31
C. Length of stay in Baltimore: 8 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-02 M
D. STREET ADDRESS (If rural, give location): 3032 Seamon Ave. - 25

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 19, 1935
9. AGE (In years last birthday): 14 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School - Girl
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Emeary Williams
14. MOTHER'S MAIDEN NAME: Ida Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Sub-acute Bacterial Endocarditis (Cured)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 27, 19 49 *to* Jan. 11, 19 50 *that I last saw the deceased alive on* Jan. 11, 19 50, *and that death occurred at* 4.20 PM *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Bogen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arbutus
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. L. Nelson
ADDRESS: 1303 Pennsylvania Ave.

VS 150

0339

58D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-52

50 0341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

570.5

Registered No. 50 0341

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Hawkins

2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days — Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 1717 Westwood Ave

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7-2-86
9. AGE (In years last birthday): 63 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Transit Co.
11. BIRTHPLACE (State or foreign country): Prince Ges. Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unobtainable
14. MOTHER'S MAIDEN NAME: unobtainable
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B) Peritoneal Adhesions — ?

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/11, 1950, *to* 1/12, 1950, *that I last saw the deceased alive on* 1/12, 1950, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE: David Sukeus, M. O.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Barrington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. G. Kelson
ADDRESS: 1303 Pressman St

VS 150

988 49

122 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-500

CERTIFICATE CORRECTED 8-22-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143

BIRTH NO. 50 0342 ~~B-~~ 112242

Registered No. 50 0342

1. NAME OF DECEASED (Type or Print): Nathaniel Boon or Nathaniel Boone

2. DATE OF DEATH: 1-6-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
31
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1714 Madison Ave.

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ~~Single~~ ?
8. DATE OF BIRTH: ? ? ?
9. AGE (In years last birthday): 70 ?
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed for 2 1/2 yrs
10B. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio Vascular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis

19A. DATE OF OPERATION: 12-30-49
19B. MAJOR FINDINGS OF OPERATION: Amputation Rt. Foot.
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17-47, 19__, *to* Jan. 6, 1950, *that I last saw the deceased alive on* Jan. 6, 1950, *and that death occurred at* 9 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Chozen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. H. Kelson ADDRESS: 1383 Pressman St.

VS 150

4500 0341

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-654

50 0343

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 20.0 50 0343

Registered No.

1. NAME OF DECEASED (Type or Print): George F. Cromwell

2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. General Hosp.
43
C. Length of stay in Baltimore: 66 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-03
D. STREET ADDRESS (If rural, give location): Trailer-Ft. of Hanover St. at Bridge

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 1, 1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Ship-Repair Yard
11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas I. Cromwell
14. MOTHER'S MAIDEN NAME: Ann Mitchell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Wm. A. Cromwell (Bro.) — ADDRESS: 530 E. Clement St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

(B) Coronary Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10-, 1950 *to* 1-12-, 1950, *that I last saw the deceased alive on* 1-12-, 1950, *and that death occurred at* 12 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry D. Gregorian M. D.
23B. ADDRESS: So. Balto. Gen. Hosp.
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
24D. LOCATION (City, town, or county) (State): A.A.Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Howard Evans
ADDRESS: 1400 S. Charles St. Balto. 30, Md.

VS 150

30844

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-525

JENKINS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0344

Registered No. 50 0344

1. NAME OF DECEASED (Type or Print): James Jenkins 754.0

2. DATE OF DEATH: January 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
23
C. Length of stay in Baltimore: 7 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Kans.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lincoln
D. STREET ADDRESS (If rural, give location): 5065.4 th St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 6-26-44
9. AGE (In years last birthday): 5 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul Jenkins
14. MOTHER'S MAIDEN NAME: Rosie Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Tetralogy of Fallot Congenital

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/7/50
19B. MAJOR FINDINGS OF OPERATION: Tetralogy of Fallot
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-29, 1949, *to* 1-12, 1949, *that I last saw the deceased alive on* 1-12, 1949, *and that death occurred at* 7 30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clifton F. Kieffer, Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Lincoln, Kansas.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John C. Mitchell Sons — ADDRESS: 1900 Eutaw Pl.

VS 150

157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0345

Registered No. 50 0345

BIRTH NO. 50 0345

1. NAME OF DECEASED (Type or Print): Delia Bowman

2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged
C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1200 Valley St

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: Nov. 11, 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Cosby
14. MOTHER'S MAIDEN NAME: Alice Vogel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sister Superior ADDRESS: 1200 Valley St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

ANTECEDENT CAUSES

(B) Chronic Myocarditis — 6 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arterio Sclerosis — 10 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1 —, 1949, to Jan 12 —, 1950, that I last saw the deceased alive on Jan 12, 1950, and that death occurred at 2 A ~~P.M.~~, from the causes and on the date stated above.

23A. SIGNATURE: E Gill Hall M D M. D.
23B. ADDRESS: 1631 E. North Ave
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld
ADDRESS:

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-6 20

50 0346

BIRTH NO. 49-18224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0346

1. NAME OF DECEASED (Type or Print): CARL HARRY KRUG

2. DATE OF DEATH: JANUARY 12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25-0311
D. STREET ADDRESS (If rural, give location): 2829 INDIANA AVENUE - 30

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: AUG 30, 1949
9. AGE (In years last birthday): If Under 1 Year: Months 4, Days 13; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM HERMAN KRUG
14. MOTHER'S MAIDEN NAME: ANNA ~~B~~ OLLETTE DEMBINSKY ~~KRUG~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ANNA J. KRUG ADDRESS: 2829 INDIANA AVE -30

MEDICAL CERTIFICATION

18. 293 X

CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ANEMIA — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

over

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 12, 1950, *to* Jan 12, 1950, *that I last saw the deceased alive on* Jan 12, 1950, *and that death occurred at* 1 to P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Latimer G. Young M. D.
23B. ADDRESS: UNIVERSITY HOSPITAL
23C. DATE SIGNED: JAN 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16 50
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry K. Kittle
ADDRESS: 4101 Edmondson Ave

VS 150

73D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

24065

No further diagnosis can be given. Letter in document file.
50-0346 - 3/31/50.

H-620

MS--134829

50 0347

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 50 0347

1. NAME OF DECEASED (Type or Print): Willie Harris 00

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 5 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland ?
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halethorpe
D. STREET ADDRESS (If rural, give location): 1830 Woodside Ave., Halethorpe, Md.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1/3 /1890
9. AGE (In years last birthday): 60 ? | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Housing Corp.
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? ?
14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 233-24-5853
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO X

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9- *, 1950, to* 1-12- *, 1950, that I last saw the deceased alive on* 1-12- *, 1950, and that death occurred at* 8:15A *m., from the causes and on the date stated above.*

23A. SIGNATURE: P. L. Cogen M. D.
23B. ADDRESS: B. C. H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Staunton Virginia

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Applegate Inc. ADDRESS: 1328 Sulphur Spring Rd.

VS 150

602 V9

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-300

50 0348
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

44

50 0348
Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES W. P. SCHAD

2. DATE OF DEATH: Jan. 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1803 Poplar Grove St.
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 1803 Poplar Grove St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 26, 1867
9. AGE (In years last birthday): 82 yrs.
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier (rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Federal Post Office
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Schad
14. MOTHER'S MAIDEN NAME: Emma Jaeger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. C. Irvin Schad
ADDRESS: 1803 Poplar Grove St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Renal-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

(B) uremia — 3 days

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 9, 1950 *to* Jan 11, 1950, *that I last saw the deceased alive on* Jan 11, 1950 *and that death occurred at* 6:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel P. Robinson M. D.
23B. ADDRESS: 2835 Guy Mills Rolls Ave
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

222 95

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-652

50 0349

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44v Registered No. 50 0349

1. NAME OF DECEASED (Type or Print): Harry Corwish

2. DATE OF DEATH: 1-7-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 18-02
D. STREET ADDRESS (If rural, give location): 500 N Carlington Ave.

5. SEX: m
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widower
8. DATE OF BIRTH: Sept 15-1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months 3 Days 23
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Easton R.D. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm H. Corwish
14. MOTHER'S MAIDEN NAME: Polley Wiley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 218-16-6318
17. INFORMANT: James Corwish ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acidosis
DUE TO
(B) Renal failure
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Myocardial decompensation - atelectasis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1st, 1950, *to* Jan 7th, 1950, *that I last saw the deceased alive on* Jan. 7th, 1950, *and that death occurred at* 5 45A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Fred R. McCluskey M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 1-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/50
24C. NAME OF CEMETERY OR CREMATORY: Unionville, Easton Road
24D. LOCATION (City, town, or county) (State): Easton Rural Md

DATE RECEIVED BY LOCAL REGISTRAR: 1/11/50
REGISTRAR'S SIGNATURE: Thos. J. Mitchell M.D.
25. FUNERAL DIRECTOR: John D. Williams ADDRESS:

JAN 13 1950

98899

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Correct spelling of street & phone to Hospital 2/16/49 -
Mr Arrapeale

S-325

50 0350
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E981.

Registered No. 50 0350

1. NAME OF DECEASED (Type or Print): JOSEPH Staskunas ~~STASKUNOT~~ N8614

2. DATE OF DEATH: January 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 30 S. Albemarle Street
C. Length of stay in Baltimore 38 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 30 S. Albemarle Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: December 8, 1898
9. AGE (In years last birthday): 51 52 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10B. KIND OF BUSINESS OR INDUSTRY: STEEL MFG. ~~Unknown~~
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? Lithuania

13. FATHER'S NAME: Staskunas, Igngeis
14. MOTHER'S MAIDEN NAME: Grigaite, Katrina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-24-5108
17. INFORMANT: Catherine Staskunas ADDRESS: 30 S. Albemarle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wound of heart
DUE TO
(B) Cardiac Tamponade
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 30 S. Albemarle Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 11, 1950 ? A.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 14, 1950
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Mt. Carmel Road
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles H. Jackanicz
ADDRESS: 703 N. Henry

VS 151 49629 166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-460

50 0351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0351 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): McCormick Taylor

2. DATE OF DEATH: January 11 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2035 N Washington St
C. Length of stay in Baltimore (Yrs. Mos. Days): 45 years

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 2035 N Washington St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept 281874
9. AGE (In years last birthday): 75
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Bank
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Zachary Taylor
14. MOTHER'S MAIDEN NAME: Martha Ellen Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or noknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-14-1303
17. INFORMANT: Mrs Margaret Taylor (WIFE) ADDRESS: 2035 Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

(B) Mitral Stenosis — 5 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteria Sclerosis — 10 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mch 2 –, 1949, *to* Jan 11, 1950, *that I last saw the deceased alive on* Jan 11, 1950, *and that death occurred at* 10-15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall MD M. D.
23B. ADDRESS: 1631 E North Ave
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 14 1950
24C. NAME OF CEMETERY OR CREMATORY: Friendship Cemetery
24D. LOCATION (City, town, or county) (State): Friendship Anne Arundel Co Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 13 1950
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: J Melville Jenkins
ADDRESS: 2713 KIRK AVE Balto Md

VS 150

6028V

92B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-3165

BIRTH NO. 50 0352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

Registered No. 50 0352

1. NAME OF DECEASED (Type or Print): Della Stern 515-478

2. DATE OF DEATH: Jan 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 1009 Collman Ave

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2-19-11
9. AGE (In years last birthday): 38
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Stern
14. MOTHER'S MAIDEN NAME: Jennie Abram

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cecum (Bowel) — INTERVAL BETWEEN ONSET AND DEATH: 7 mo

DUE TO

(B) None

DUE TO

(C) None

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct 06/14/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Cecum with Metastises
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 28, 1949, *to* Jan 14, 1950, *that I last saw the deceased alive on* Jan 14, 1950, *and that death occurred at* 9 00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph D. B. King M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: Jan 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY: Evergreen Grad.
24D. LOCATION (City, town, or county) (State): Washington DC

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: B. Danzansky & Sons
ADDRESS: 3501-9 4 St NW Washington DC

VS 150

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-651

50 0353

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 16r 50 0353

Registered No.

1. NAME OF DECEASED (Type or Print): Fran K Hornberger

2. DATE OF DEATH: 1/13/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 24 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Perryville
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11/5/1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Conductor
10B. KIND OF BUSINESS OR INDUSTRY: Pen. Railroad
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Hornberger (dec'd)
14. MOTHER'S MAIDEN NAME: Louise Booth (dec'd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ora F. Hornberger ADDRESS: Perryville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, left lung — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) C metastasis — 6-8 months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/19, 1949, *to* 1/13, 1950, *that I last saw the deceased alive on* 1/13, 1950, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert J. Lesicka M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: Asbury
24D. LOCATION (City, town, or county) (State): Perryville, Cecil Co., Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lee Patterson & Son
ADDRESS: Perryville, Md.

VS 150

10247

47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-432

50 0354

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 50 0354

331

1. NAME OF DECEASED (Type or Print): Klutch, Amelia H.

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): St. Joseph's
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Dundalk
D. STREET ADDRESS (If rural, give location): 3012 Dunglow Rd., Dundalk

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 8/29/1868
9. AGE (In years last birthday): 81
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Muller
14. MOTHER'S MAIDEN NAME: Dorothy Karkheck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah C. Hammer ADDRESS: 300 E. 31st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C) Arteriosclerosis, generalized

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 11, 1950 *to* Jan. 13, 1950, *that I last saw the deceased alive on* Jan. 13, 1950, *and that death occurred at* 6:58a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Sivinski M. D.
23B. ADDRESS: 1400 N. Carolines St.
23C. DATE SIGNED: Jan. 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. C. Cook Inc.
ADDRESS: 517 St. Paul St.

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R-220

Reisig

50 0355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59

Registered No. 50 0355

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REISIG, Joseph A.

2. DATE OF DEATH: 1-12-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 26-03
D. STREET ADDRESS (If rural, give location): 3311 Dudley Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3/19/1904
9. AGE (In years last birthday): 45
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contracting Painter
10B. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Reisig
14. MOTHER'S MAIDEN NAME: Anna Betz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Frances Reisig
ADDRESS: 3311 Dudley Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia, Acidosis

DUE TO

ANTECEDENT CAUSES

(B) Chronic Nephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-12-1950
19B. MAJOR FINDINGS OF OPERATION: free peritoneal fluid
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9, 1950 *to* 1-12, 1950 *that I last saw the deceased alive on* 1-12, 1950 *and that death occurred at* 5:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: James M. Bisanar M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge
24D. LOCATION (City, town, or county) (State): Dorsey Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Gotz Inc.
ADDRESS: 1217 St. Paul St.

VS 150

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61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-520

50 0356

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110

Registered No. 50 0356

1. NAME OF DECEASED (Type or Print): Rose Manka

2. DATE OF DEATH: January 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 15 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 615 N. Eutaw St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7-17-03
9. AGE (In years last birthday): 46
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Chicago Ill.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Thompson.
14. MOTHER'S MAIDEN NAME: Sanbike Hanko

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO (B) Aortic Insufficiency / Mitral Stenosis and Insuff — 30 yrs.

DUE TO (C) Chronic Rheumatic Heart Disease / Renal Infarcts

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31, 1949, *to* 1-12, 1950, *that I last saw the deceased alive on* 1-12, 1950, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Katherine H. Borkovich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cox & Sons
ADDRESS: 1217 St. Paul st.

VS 150

92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

E 562

50 0357

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 r.1

50 0357

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE HARRINGTON EMERSON

2. DATE OF DEATH: 1-12-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 12-01
D. STREET ADDRESS (If rural, give location): 210 Lombard Road

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug 11, 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED EXECUTIVE
10B. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Horace Emory Emerson
14. MOTHER'S MAIDEN NAME: Emma Kittridge
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-12-1438
17. INFORMANT: HOSPT. RECORDS ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diverticulitis of rectum & sigmoid
DUE TO peri rectal abscess

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH: 2 to 3 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1950, *to* Jan 12, 1950, *that I last saw the deceased alive on* Jan 12, 1950, *and that death occurred at* 11:21 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. E. Cox 3d M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-1950
24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE
24D. LOCATION (City, town, or county) (State): PIKESVILLE MD.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H.W. JENKINS & SONS CO.
ADDRESS: 4905 YORK RD.

VS 150

156 47

61

G 655

50 0358

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 0.2

50 0358

Registered No.

1. NAME OF DECEASED (Type or Print): William J Groeninger

2. DATE OF DEATH: 1/12/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 4-02
D. STREET ADDRESS (If rural, give location): 324 N. Paca St.

5. SEX: MALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: Aug 11 1857
9. AGE (In years last birthday): 92. If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photographer
10B. KIND OF BUSINESS OR INDUSTRY: Commercial Own Business
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Groeninger
14. MOTHER'S MAIDEN NAME: Margaret Kreis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: W. J. Groeninger ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Superior Mesenteric Thrombosis & gangrene of small & large intestine — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis generalized

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerotic cardiovascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1949, to 1/12, 1950, that I last saw the deceased alive on 1/12, 1950, and that death occurred at 7:10 A m., from the causes and on the date stated above.

23A. SIGNATURE: Mark E Hall M. D.
23B. ADDRESS: U of Md Hospital
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Jan 16 1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Henry N. Jenkins & Sons Co
ADDRESS: 4905 York Rd.

VS 150

V6689

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and completely.

U-243

50 0359 134865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0359

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Juliet Usilton

2. DATE OF DEATH: 1-12-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days): ?

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06
D. STREET ADDRESS (If rural, give location): 2822 W. Lanvale St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jul. 12, 1878
9. AGE (In years last birthday): 71 ?
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: B. C. H. Records
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pulmonary Tuberculosis	
	DUE TO	
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 11, 1950, *to* Jan. 12, 1950 *that I last saw the deceased alive on* Jan. 12 1950, *and that death occurred at* 5.22 pm, *from the causes and on the date stated above.*

23A. SIGNATURE: H. Rogers M. O.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: St. Peters
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr.
25. FUNERAL DIRECTOR: J. T. Stansbury
ADDRESS: 2700 Edmondson Ave.

VS 150

0358

13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

S-530

50 0360

BIRTH NO. 49-28056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0360

1. NAME OF DECEASED (Type or Print): Baby Smith, (Martin Charles)

2. DATE OF DEATH: 1/13/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. Agnes
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hosp.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE U.S.A. Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 28-01
D. STREET ADDRESS (If rural, give location): 6700 Reisterstown Rd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12/24/49
9. AGE (In years last birthday): 20 days — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Rose Marie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Duodenal Atresia (1st portion Duodenum) — INTERVAL BETWEEN ONSET AND DEATH: 2 days, Congenital

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition, Dehydration, Distention & hyperpnea fly Stomach; Confluent lobular pneumonia

19A. DATE OF OPERATION: 12/29/49
19B. MAJOR FINDINGS OF OPERATION: Abdominal Goitrous & high Intestinal obstruct
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/23, 1949, to 1/13, 1950, that I last saw the deceased alive on 1/13, 1950, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE: B. Ramirez M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-50
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): German Hill Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. J. Fahey & Son
ADDRESS: 1315 Light St.

VS 150

1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

J-520

50 0361
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

11

Registered No. 50 0361

1. NAME OF DECEASED (Type or Print): Candress Jones
2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital
C. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 1908 W. Franklin St.

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 29, 1907
9. AGE (In years last birthday): 42 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator in Sugar Refinery
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Jones
14. MOTHER'S MAIDEN NAME: Lala Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Eulala Jones
ADDRESS: 1908 W. Franklin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 14 months.

DUE TO

ANTECEDENT CAUSES

(B) Unknown

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 31, 1949 *to* Jan 12, 1950, *that I last saw the deceased alive on* Jan 12, 1950, *and that death occurred at* 5:02 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: President Hospital
23C. DATE SIGNED: Jan 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: Alberts Cemetery
24D. LOCATION (City, town, or county) (State): Ahoskie, N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: THE CHARLES R. LAW MORTUARY
ADDRESS: 802-04 MADISON AVENUE
BALTIMORE 1, MD.

VS 150

496X6

48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F-630

50 0362

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6452 Registered No. 50 0362

1. NAME OF DECEASED (Type or Print): GLADYS K. GOODMAN FORD

2. DATE OF DEATH: January 11, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3700 Liberty Heights Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 1001 Harlem Avenue

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: October 11, 1924
9. AGE (In years last birthday): 25
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George M. Goodman
14. MOTHER'S MAIDEN NAME: E. Katherine Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Katherine Colburn
ADDRESS: 1001 Harlem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive hemo-peritoneum
DUE TO ruptured ectopic pregnancy

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Catatonic schizophrenia -- Electric shock therapy

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): doctor's office
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3700 Liberty Heights Avenue 15/11
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 11, 1950 2:35 P.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Patient died 20 minutes after electric shock convulsion

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Carl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams
ADDRESS: 322 N

VS 151

142 B

P-620

50 0363
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

334

50 0363
Registered No.

1. NAME OF DECEASED (Type or Print): JESSIE LOUISE PARKS

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3052 Brighton St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3052 Brighton St.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Dec. 9, 1883
9. AGE (In years last birthday): 66 yrs.
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Oriole, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Christopher Summers
14. MOTHER'S MAIDEN NAME: Cora Hasting

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Mr. John E. Parks
ADDRESS: 3052 Brighton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Apoplexy. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO and Hypertension

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov, 1949, *to* Jan. 13, 1950, *that I last saw the deceased alive on* Jan 13, 1950 *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3033 W Northern
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial--
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Lincoln Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

50 0362

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W-452

BIRTH NO. 50 0364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 0364

1. NAME OF DECEASED (Type or Print): Ida E. Williams 201

2. DATE OF DEATH: 1/13/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2601 Roslyn Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2601 Roslyn Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville
D. STREET ADDRESS (If rural, give location): 513 Sudbrook Rd.

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 22, 1884
9. AGE (In years last birthday): 65 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never employed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard H. Williams
14. MOTHER'S MAIDEN NAME: Ida E. Brian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. John Williams ADDRESS: 2918 N. Rogers Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkin's Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948 *to* 1-13, 1950 *that I last saw the deceased alive on* 1-12, 1950 *and that death occurred at* 1 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lillian L. Fleavis M. D.
23B. ADDRESS: 3025 Belair Road
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Remington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS,
ADDRESS: Balto., Md.

0 3 6 3

VS 150

448

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

D+620

CERTIFICATE CORRECTED 1-23-1950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

274

50 0365 Registered No.

50 0365 BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES DeRake

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4015 Kathland Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-10
D. STREET ADDRESS (If rural, give location): 4015 Kathland Ave.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 23, 1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Drugs
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James DeRake
14. MOTHER'S MAIDEN NAME: Maria Moser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-22-4354
17. INFORMANT: Mrs. Pearl De Rake
ADDRESS: 4015 Kathland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Addison's Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 13, 19[illegible], *to* Jan 13, 1950, *that I last saw the deceased alive on* Jan 13, 1950, *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 404 Eutaw Place
23C. DATE SIGNED: Jan 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Crem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Timothy Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

0364

VS 150

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65a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

F-150

BIRTH NO. 50 0366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.1

Registered No. 50 0366

1. NAME OF DECEASED (Type or Print): HARRY FABIAN

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 10 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 2410 Eutaw Place

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 14, 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman Fire Proofing Material
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Fabian
14. MOTHER'S MAIDEN NAME: Rachael Silk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Sadie Fabian
ADDRESS: 2410 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 16, 1950
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Chas. Wm. Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bro
ADDRESS: 1826 W Northwest

VS 151

272 V9

0 3 675

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-435

50 0367

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4700

Registered No. 50 0367

1. NAME OF DECEASED (Type or Print): Sarah Altman

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3411 Rogers Avenue
C. Length of stay in Baltimore: 50 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 3411 W. Rogers Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1887
9. AGE (In years last birthday): 62 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Columbus
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Samuel Altman — ADDRESS: 3411 West Rogers Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio Sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1945

DUE TO

(B) general arterio Sclerosis — 1945

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-8, 1945 *to* 1-13, 1950 *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 12:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. A. Michelson, M. D.
23B. ADDRESS: 2230 Eutaw Pl.
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY: Brai Israel
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Minnie Victor Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bros
ADDRESS: 1124-26 W. North Avenue

VS 150

93D

D-500

50 0368
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0368
Registered No.

1. NAME OF DECEASED (Type or Print) FRED. DONOHO

2. DATE OF DEATH Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.
C. Length of stay in Baltimore 60 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-10 Md.
D. STREET ADDRESS (If rural, give location) #2 Beechdale Rd. 27-13

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Dec. 16, 1869
9. AGE (In years last birthday) 80
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None retired
10B. KIND OF BUSINESS OR INDUSTRY Strayers Bus. College
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Richardson Donoho
14. MOTHER'S MAIDEN NAME Elizabeth Ann Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT Mr. John F. Donoho
ADDRESS Princeton, N.J. 80 Cleveland Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute episode of Chronic bronchitis
DUE TO
(B) Fail'd cardiac failure
DUE TO
(C) arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. senility

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14, 1949, *to* 1-13, 1950, *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 10:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE J. Frank Supplee, III M. D.
23B. ADDRESS Union Memorial Hosp
23C. DATE SIGNED Jan 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/16/50
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 14 1950
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John O. Mitchell Sons
ADDRESS 1900 Eutaw Place

VS 150

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93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-500

50 0369
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

N 60

50 0369
Registered No.

1. NAME OF DECEASED (Type or Print): George H. Lyon

2. DATE OF DEATH: Jan 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2900 Alameda, Blvd
B. FULL NAME OF ~~HOSPITAL OR INSTITUTION~~ (If not in hospital or institution, give street address or location): [redacted]
C. Length of stay in Baltimore: 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md
D. STREET ADDRESS (If rural, give location): 3217 n. Calvert, St 12-2

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Nov. 16, 1870
9. AGE (In years last birthday): 79 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. of Buildings
10B. KIND OF BUSINESS OR INDUSTRY: C. & P. Tel. Co.
11. BIRTHPLACE (State or foreign country): New York, N. Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harvey Lyon
14. MOTHER'S MAIDEN NAME: Thizer Brundage N.Y.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Edith A. Lockyer Rowan Arms White — ADDRESS: Plains

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Degeneration Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs -
DUE TO
(B) Myocardial failure — 2 yrs -
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* 1/13, 1950, *that I last saw the deceased alive on* 1/13, 1950, *and that death occurred at* 9 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: James L. Warden Jr M. D.
23B. ADDRESS: 2900 Alameda Blvd
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Bedford Union Cemetery
24D. LOCATION (City, town, or county) (State): Bedford, N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John G. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-536

50 0370

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0370

Registered No.

1. NAME OF DECEASED (Type or Print): Cassian Andrews 154

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bon Secours Hos.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34
C. Length of stay in Baltimore 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 29 W. North Ave. 12-5

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 5/5/1894
9. AGE (In years last birthday): 55 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Erwin, S. D.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cassian Andrews
14. MOTHER'S MAIDEN NAME: Sarah Ingalls

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Sara R. Andrews — ADDRESS: 29 W. North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, Return, Bladder — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

DUE TO

(B) Myocardial failure, acute — 3 days

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-3-50
19B. MAJOR FINDINGS OF OPERATION: Carcinoma, Return, Bladder
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1949 *to* 1-13, 1950, *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 9:15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph R. Oake M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16, 1950
24C. NAME OF CEMETERY OR CREMATORY: All Saints Church
24D. LOCATION (City, town, or county) (State): St. Marys Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. D. Mitchell Sons.
ADDRESS: 1900 Eutaw Place

VS 150

12481

461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W-436 204.4

BIRTH NO. 50 0371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X

Registered No. 50 0371

1. NAME OF DECEASED (Type or Print): Harry Walters. 5-19-04

2. DATE OF DEATH: JAN 14 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boring
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wd.
8. DATE OF BIRTH: 10-21-64
9. AGE (In years last birthday): 85 86 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Balto Co
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Henry Walter
14. MOTHER'S MAIDEN NAME: Sarah Sadd
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undiagnosed disease of blood forming organs manifested by
DUE TO
(B) monocytosis & anemia —
DUE TO
? leukemia —
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-, 1950, *to* 1-14-, 1950, *that I last saw the deceased alive on* 1-14-, 1950, *and that death occurred at* 1:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edyth H. Schoenrich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17-50
24C. NAME OF CEMETERY OR CREMATORY: St Paul.
24D. LOCATION (City, town, or county) (State): Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. F. Elms. Sons — ADDRESS: Rustburg, Md.

VS 150

74a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-650

BIRTH NO. 50 0372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0372

1. NAME OF DECEASED (Type or Print): Rose Moran

2. DATE OF DEATH: 1/12/50

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore (Yrs. Mos. Days): 43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1624 E. North Ave. 8-5

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 12/21/1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Heitzer
14. MOTHER'S MAIDEN NAME: Catherine Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family - Same
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B) Coronary occlusion

DUE TO

(C) Coronary arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9, 1950 *to* 1/12, 1950 *that I last saw the deceased alive on* 1/12, 1950, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry D. Gorrie M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 1/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 14 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCurley
ADDRESS: 130 E. Fort Ave.

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E-152

BIRTH NO. 50 0373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1

Registered No. 50 0373

1. NAME OF DECEASED (Type or Print): Jesse C Evans

2. DATE OF DEATH: Jan 14, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 3025 Windsor Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,

D. STREET ADDRESS (If rural, give location): 643 E Clement St 24-02

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 22, 1872

9. AGE (In years last birthday): 77 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10B. KIND OF BUSINESS OR INDUSTRY: Fishing

11. BIRTHPLACE (State or foreign country): York County, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Evans

14. MOTHER'S MAIDEN NAME: Elmira Wainwright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: W E Francis ADDRESS: 3307 Dorchester Rd Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* Jan 14, 1950, *that I last saw the deceased alive on* Jan 14, 1950, *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W Paul Byrne M. D.

23B. ADDRESS: 3033 W Monroe A

23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: Jan 15, 1950

24C. NAME OF CEMETERY OR CREMATORY: York County, Va

24D. LOCATION (City, town, or county) (State): York County, Va (near) Grafton

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St Paul St Balto, Md.

MS 155

JAN 15 1950

900 V1

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94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0374 T-425

50 0374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

023

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Monroe Tilghman

2. DATE OF DEATH: JAN 12 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 602 W. Lee St 22-02

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4/16/07
9. AGE (In years last birthday): 42
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Solomon Tilghman
14. MOTHER'S MAIDEN NAME: Mary Jane Otha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Syphilitic Aortic Insufficiency — yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31- *,* 19 47 *, to* 1-12- *,* 19 50 *, that I last saw the deceased alive on* 1-12- *,* 19 50 *, and that death occurred at* 12:30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: David Lukens M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY: Madison Cem
24D. LOCATION (City, town, or county) (State): Madison Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 15 1950
REGISTRAR'S SIGNATURE: Mrs. Madison, Md
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1005 Brantly

908-95

30D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and concisely.

C-615

50 0375

50 0375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15-5

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH H. CARPENTER

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3308 Liberty Heights Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3308 Liberty Hgts. Ave. 15-11

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 15, 1867
9. AGE (In years last birthday): 82
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Weikel
14. MOTHER'S MAIDEN NAME: Sarah Ermentrout

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. W. B. Carpenter
ADDRESS: 3308 Liberty Hgts. Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Liver. — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos.

DUE TO Primary -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-19-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma - Primary Liver.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* 1-13, 1950, *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Howard H. Warner M. D.
23B. ADDRESS: 2604 Garrison Blvd
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: Elias Cemetery
24D. LOCATION (City, town, or county) (State): Newmanstown, Pa.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto. Md.

JAN 16 1950

VS 150

46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0376 50 0376

W-420

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331 Registered No.

1. NAME OF DECEASED (Type or Print): Julia Walsh

2. DATE OF DEATH: Jan. 12, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10-1

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: Aug. 1872
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Patrick Hughes
14. MOTHER'S MAIDEN NAME: Mary Gibbons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sister Superior ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

(B) Arteio Sclerosis — 3 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 2, 1950, *to* Jan 12, 1950, *that I last saw the deceased alive on* Jan 12, 1950, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Gill Hall MD M. D.
23B. ADDRESS: 1631 E. North Ave
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 16, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: 1-15-50
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Rita Wagefeld
ADDRESS: 900 E. Biddle St

VS 150

8 3a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

50 0377

H-430

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H.O. 1 50 0377

Registered No.

1. NAME OF DECEASED (Type or Print): Justin Held

2. DATE OF DEATH: Jan. 14 '50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 11 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2500 Park Heights Ter.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 45 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Floor Covering
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gustave
14. MOTHER'S MAIDEN NAME: Freda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10-12 hrs

DUE TO

(B) Coronary occlusion — 10-12 hrs

DUE TO

(C) Coronary artery sclerosis — 8 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14- *, 19*50 *to* 1-14- *, 19*50 *that I last saw the deceased alive on* 1-14 *, 19*50 *, and that death occurred at* 1:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ernest C. Brown Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-15-50
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: 1-15-50
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Jack Frazier Inc
ADDRESS: 2100 Eutaw Pl

VS 150

29867

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-350
50 0373

50 0378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E-936.7

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL JANNEY HUTTON, JR. N-991

2. DATE OF DEATH: 1/15/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: UNK. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: VIRGINIA
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLASGOW
D. STREET ADDRESS (If rural, give location): —

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: JAN 9, 1936
9. AGE (In years last birthday): 14
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10B. KIND OF BUSINESS OR INDUSTRY: Hy. School.
11. BIRTHPLACE (State or foreign country): CONNECTICUT
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL J. HUTTON, SR
14. MOTHER'S MAIDEN NAME: NANCY CHAMBERLAIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: FATHER
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral edema — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Strangulation — 5 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary edema

CERTIFICATION APPROVED BY
DR. JOHN R. DOVIS
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): school
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): St. Paul's School
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 5 P.M. 1-10-50 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Found hanging from rope by neck

22. I hereby certify that I attended the deceased from 1/10, 1950, to 1/15, 1950, that I last saw the deceased alive on 1/15, 1950, and that death occurred at 2:15 A.m., from the causes and on the date stated above.

23A. SIGNATURE: W. F. Cox 3d M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Woodside Cemetery
24D. LOCATION (City, town, or county) (State): Olney - Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [illegible] M.D.
25. FUNERAL DIRECTOR: Robert Humphrey
ADDRESS: Rockville Md

VS 150

1956

JAN 15 1950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0379 Registered No. 50 0379

1. NAME OF DECEASED (Type or Print): Cora Estelle Grove

2. DATE OF DEATH: 1-15-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1804 Rosedale St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore: 7 months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 1804 Rosedale St.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10-15-1871
9. AGE (In years last birthday): 79 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Huff
14. MOTHER'S MAIDEN NAME: Mary? Huff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Kathleen Pitt — ADDRESS: 34 N. Davidsonville Road Gambrills - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

ANTECEDENT CAUSES

(B) Chronic Myocarditis — 1 yr.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 29, 1949 *to* Jan 14, 1950 *that I last saw the deceased alive on* Jan 14, 1950 *and that death occurred at* 9:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Isaac C. Dickson M. D.
23B. ADDRESS: 3055 W. North Ave
23C. DATE SIGNED: Jan 15, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-1950
24C. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
24D. LOCATION (City, town, or county) (State): Frederick - Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. E. Ching & Son — ADDRESS: Frederick Md.

VS 150

937

B-453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0380 48-16792 | 1953 | Registered No. 50 0380

1. NAME OF DECEASED (Type or Print): (Melva) Melva Blount
2. DATE OF DEATH: Jan. 13, 1950
3. PLACE OF DEATH:
A. Baltimore City, Maryland HH 4E.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 17 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1216 Madison ave
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 8-5-48
9. AGE (In years last birthday): If Under 1 Year: Months 17; Days; If Under 24 Hours: Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Melvin Blount
14. MOTHER'S MAIDEN NAME: Virginia Wallis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor - Ependymoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21-, 19 49, *to* 1-13-, 19 50, *that I last saw the deceased alive on* 1-18-, 19 50 *and that death occurred at* 4 20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harrison Spencer M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 - Druid Hill ave.

VS 150

54a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-252

50 0381
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0381

1. NAME OF DECEASED (Type or Print): WASHINGTON, Charles
2. DATE OF DEATH: 1/13/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 765 W. Mulberry

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 68 67 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Balts. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Martha Smothers — ADDRESS: 765 Mul. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/12 *, 19*50*, to* 1/13 *, 19*50*, that I last saw the deceased alive on* 1/12 *, 19*50*, and that death occurred at* 8 *am., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.
25. FUNERAL DIRECTOR: W. Halstead
ADDRESS: 918 Druid Hill Ave.

VS 150 988 V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

H-300

50 0382

BIRTH NO. 50-N0956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 50 0382

1. NAME OF DECEASED (Type or Print): BABY BOY HEATH

762.0

2. DATE OF DEATH: 1.14.50.

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
C. Length of stay in Baltimore: 1 Days (~~Yrs. Mos.~~)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Loch Raven
D. STREET ADDRESS (If rural, give location): Smith Ave -

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1.13.50
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 1 / If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: RICHARD R. HEATH
14. MOTHER'S MAIDEN NAME: MERLE E. GRAMMER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: PARENTS ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Spontaneous Pneumothorax — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1.13., 1950 *to* 1.14, 1950, *that I last saw the deceased alive on* 1.14., 1950, *and that death occurred at* 8.30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: R Becher M. D.
23B. ADDRESS: Sinai Hospital Baltimore
23C. DATE SIGNED: 1.14.50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Timothy J. Hilliard, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 1400 Belair Rd

VS 150

161a

A-165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162.0

Registered No. 50 0383

BIRTH NO. 50 0383 50-00593

1. NAME OF DECEASED (Type or Print): BABY BOY ABRAMCZYK

2. DATE OF DEATH: 1/15/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. 36 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md 18 27-09
D. STREET ADDRESS (If rural, give location): 1628 Kingsway Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: January 1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days: 5 Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Chester Joseph Abramczyk
14. MOTHER'S MAIDEN NAME: Regina Helen Busch
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 1628 Kingsway Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/10, 1950, *to* 1/15, 1950, *that I last saw the deceased alive on* 1/15, 1950, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter K. Spelsberg M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 1/15/50

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial
24B. DATE: 1-16-50
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Dundalk, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Schiszler Funeral Home Inc.
ADDRESS:

VS 150

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

426 50 0384 BIRTH NO. 49-28465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

76 2.5 50 0384 Registered No.

1. NAME OF DECEASED (Type or Print): Baby WALKER
2. DATE OF DEATH: 1-2-50
3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days 1
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 917 Argyle Ave
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12-31-49
9. AGE (In years last birthday): If Under 1 Year: Months; Days 1; If Under 24 Hours: Hours; Min. 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: James Walker
14. MOTHER'S MAIDEN NAME: Grace Naomi Bogar
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 917 Argyle Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prolonged Cerebral Anoxia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Asphyxia Livida

DUE TO

(C) Prematurity

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-31 *19*49 *to* 1-2, *19*50, *that I last saw the deceased alive on* 1-2, *19*50 *and that death occurred at* 4:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: George McDonald M. D.
23B. ADDRESS: 644 N Carey St
23C. DATE SIGNED: 1/2/80
24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):

JOHN HOPKINS MEDICAL SCHOOL JAN 13 1950

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

Commissioner of Health

VS 150

0 3 0 3

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Call Monday

P-626

50 0385

BIRTH NO. 50-01096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X

50 0385

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Parker 174

2. DATE OF DEATH: 1/15/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenburine
D. STREET ADDRESS (If rural, give location): Crain Highway

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 1/14/50
9. AGE (In years last birthday): If Under 1 Year: Months / Days; If Under 24 Hours: Hours 25 / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): 3 lb
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Levin Randolph Parker
14. MOTHER'S MAIDEN NAME: Evelyn Pauline (Holbrook)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pre-maturity — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Resp. Failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/14 1950 *to* 1/15, 1950, *that I last saw the deceased alive on* 1/15, 1950, *and that death occurred at* 1:55 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: William S. Womack M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Denny, Inc
ADDRESS: 715 Light St

VS 150

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159

-30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520

50 0386

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0386

1. NAME OF DECEASED (Type or Print): Shirley Jones

434.1

2. DATE OF DEATH: 1/14/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP.
C. Length of stay in Baltimore: 3 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N. C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ROXBURY
D. STREET ADDRESS (If rural, give location): —

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SEP.
8. DATE OF BIRTH: Jan. 14. 1924
9. AGE (In years last birthday): 26 yrs. | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Sonnie Morton
14. MOTHER'S MAIDEN NAME: Ellie Morton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ellen Holloway
ADDRESS: 105 E. Eutaw St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure

~~DUE TO~~

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 15 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Roxbury N.C.
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc.
ADDRESS: 927-27 Mount St.

VS 151

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93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C-656

50 0387
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0387

1. NAME OF DECEASED (Type or Print) JAMES CRONNER 600.0

2. DATE OF DEATH January 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore All Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-02
D. STREET ADDRESS (If rural, give location) 817 Ostend Street

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Sept. 3 1903
9. AGE (In years last birthday) 46 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY Never Work
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dennis Cronner
14. MOTHER'S MAIDEN NAME Blanch Simmons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ethel Boon ADDRESS 817 Ostend St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pyelonephritis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congenital Kyphosis-scoliosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Jan. 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/17/1950
24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 16 1950
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Ave.

0 3 8 6

VS 151

133a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

F 622

50 0388
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

#50.0

50 0388
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): FRANCES FERGUSON (Furguson)

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore 50 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 812 W. Ostend Street

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 9/19/1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Unkown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknowo): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Gray ADDRESS: 812 Ostend St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteio-Sclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co.Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Elroy C. Wilson ADDRESS: 1000 Brantly Ave

VS 151

97

C-652

50 0389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

464

Registered No. 50 0389

BIRTH NO. 50 0389

Cornish

1. NAME OF DECEASED (Type or Print): Reuben L. Cornish

2. DATE OF DEATH: January 12, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 33 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1216 Division St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4-8-1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George White
14. MOTHER'S MAIDEN NAME: Lda Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-20-6926
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

(B) Thrombophlebitis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cancer of breast

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1950, *to* 1-12, 1950, *that I last saw the deceased alive on* 1-12, 1950, *and that death occurred at* 9 15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter L. Arons M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Arburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Ave

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-452

50 0390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

753.1

X

50 0390

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Anne Williams

2. DATE OF DEATH: 14 January 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIV. OF Md. HOSPITAL
C. Length of stay in Baltimore: 2 mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: BALTO.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ESSEX
D. STREET ADDRESS (If rural, give location): 1603 GAIL Rd.

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 20 MARCH, 1943
9. AGE (In years last birthday): 6
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS WILLIAMS
14. MOTHER'S MAIDEN NAME: FRANCES E. MINNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: THOMAS WILLIAMS — ADDRESS: 1603 GAIL Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydrocephalus

DUE TO

ANTECEDENT CAUSES

(B) Arnold Chiari malformation

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) lumbar myelodysplasia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: Hydrocephalus
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 November 1949, to 14 Jan, 1950, that I last saw the deceased alive on 14 Jan, 1950, and that death occurred at 8 A m., from the causes and on the date stated above.

23A. SIGNATURE: Jose A Alvarez-de Choudens M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 14 Jan 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 16 JAN, 1950
24C. NAME OF CEMETERY OR CREMATORY: OAK LAWN
24D. LOCATION (City, town, or county) (State): EASTERN AVE, BALTO. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Walter Brooks Bradley, Dundalk
ADDRESS:

VS 150

0 5 0 0 0 3 8 9

157a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-324

50 0391
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0391

1. NAME OF DECEASED (Type or Print): Elizabeth Detzel
2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5506 Fair Oaks Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-01
D. STREET ADDRESS (If rural, give location): 3121 Foster Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 6 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months 2 Days 9 Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Berlin, Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Janetskie
14. MOTHER'S MAIDEN NAME: Unknown Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): N
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Detzel ADDRESS: 3121 Foster Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr Cardio-vascular -renal disease decompensated — INTERVAL BETWEEN ONSET AND DEATH: Long

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rhematoid Arthritis — 15 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Decunitus of back

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sep't 16, 19~~49~~, *to* January 15, 19~~50~~, *that I last saw the deceased alive on* 1/14/50 19__, *and that death occurred at* 12:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1901 Eutaw Place, City
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc.
ADDRESS

VS 150

50 0391

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-655

50 0392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0392

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Cora B. Harman

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4201 Falls Road Apt. #1
C. Length of stay in Baltimore: 48 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 4201 Falls Road Apt. #1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: November 13, 1870
9. AGE (In years last birthday): 79 | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Jeremiah Geiman
14. MOTHER'S MAIDEN NAME: Mary E. Royer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Blanche H. Weis
ADDRESS: 4201 Falls Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular disease — 10-15 years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. *, 1948, to* Jan. 13 *, 1950 that I last saw the deceased alive on* Jan. 12 *1950, and that death occurred at* 5:50 *P. m., from the causes and on the date stated above.*

23A. SIGNATURE: Wilford H. Dannenhauer Jr. M. D.
23B. ADDRESS: 14 E. Eager St.
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 16, 1950
24C. NAME OF CEMETERY OR CREMATORY: Meadow Branch
24D. LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

93D

Mr. Townsend
14 E. Cooper St.

432

50 0393

BIRTH NO. 49-00014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

198 Registered No. 50 0393

1. NAME OF DECEASED (Type or Print): Fletcher, Beatrice Colleen

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR ~~INSTITUTION~~ (If not in hospital or institution, give street address or location): St. Joseph's
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-03
D. STREET ADDRESS (If rural, give location): 1831 S. Charles St.

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 1, 1948
9. AGE (In years last birthday): 2 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Wandel Fletcher
14. MOTHER'S MAIDEN NAME: Marcella Lorraine Fletcher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Jos. Fletcher — ADDRESS: 1831 S. Chas. St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sarcoma retroperitoneal with metastases to liver and lungs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 12, 1949, *to* Jan. 13, 1949 *that I last saw the deceased alive on* Jan. 13, 1950, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Swinski M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16, 1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. Howard Evans — ADDRESS: 1400 S. Chas. St. Balto. 30, Md.

VS 150

46H

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-123890

450

50 0394

BIRTH NO.

JAMES L. HOLIEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4720

50 0394

Registered No.

1. NAME OF DECEASED (Type or Print): James Holien (James Hollins)

2. DATE OF DEATH: Jan. 13-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 39yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 844 West Baltimore St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 4- 1869
9. AGE (In years last birthday): 81
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Blower
10B. KIND OF BUSINESS OR INDUSTRY: Bottle manufacturer
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Holiem (Hollins)
14. MOTHER'S MAIDEN NAME: Sarah Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Baltimore City Hospitals Records
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-10- , 19 49 *to* 1-13- , 19 50 *that I last saw the deceased alive on* 1-13- , 19 50 *, and that death occurred at* 5.15P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-13-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 901 Hollins

VS 150

49625

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

625

50 0395

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0395

1. NAME OF DECEASED (Type or Print): Charles Bond Groshon

2. DATE OF DEATH: 1/15/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
C. Length of stay in Baltimore: 65 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 898 W. Baltimore St.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 12/27/1882
9. AGE (In years last birthday): 67 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marble tile Setter
10B. KIND OF BUSINESS OR INDUSTRY: For Self.
11. BIRTHPLACE (State or foreign country): Frederick Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Pauline E. Groshon — ADDRESS: 898 W. Balto. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO Gen. arteriosclerosis

(C) gangrene both legs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

19A. DATE OF OPERATION: 12/27/49
19B. MAJOR FINDINGS OF OPERATION: Gangrene both feet & legs
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/9 *19*49 *to* 1/15 *, 19*50 *, that I last saw the deceased alive on* 1/15 *, 19*50 *, and that death occurred at* 4:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. E. Hawkins, Jr. M. D.
23B. ADDRESS: Franklin Sq. Hosp
23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): 3901 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 2 Collins St.

VS 150 306V9 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-400

BIRTH NO. 50 0396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0396

1. NAME OF DECEASED (Type or Print): THOMAS J. WILLIE

2. DATE OF DEATH: 1-16-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1826 E. BIDDLE ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore 25 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8-07
D. STREET ADDRESS (If rural, give location): 1826 E. BIDDLE STREET

5. SEX: MALE
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: MARCH 1. 1886
9. AGE (In years last birthday): 63 — If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JANITOR
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): PETERSBURG V.A.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: ELLEN ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.:
17. INFORMANT: LUCILLE WATERS ADDRESS: 1826 E. BIDDLE ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Jan 13, 1950 *to* Jan 16, 1950 *that I last saw the deceased alive on* Jan 13, 1950 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Francis B. Lake M. D.
23B. ADDRESS: 1501 E. Eager St.
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-18-50
24C. NAME OF CEMETERY OR CREMATORY: MT. CALVARY
24D. LOCATION (City, town, or county) (State): BALTIMORE

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Lucius Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM A. JACKSON
ADDRESS: 916 PENNA AVE

VS 150

74083

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

152

50 0397 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

330 Registered No. 50 0397

1. NAME OF DECEASED (Type or Print): RAYMOND E. HOFFMASTER

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 1501 W. Lombard Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 22, 1926
9. AGE (In years last birthday): 23 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stuffer
10B. KIND OF BUSINESS OR INDUSTRY: Calvert Dry Co
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: George H. Hoffmaster
14. MOTHER'S MAIDEN NAME: Katherine S. ~~Hiemes~~ HIMES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W. 2.
16. SOCIAL SECURITY NO.: 219-14-8829
17. INFORMANT: Betty L. Hoffmaster ADDRESS: 1501 W. Lombard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].* ✓

23A. SIGNATURE: R B Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): 5100 Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Winston Williams M.D.
25. FUNERAL DIRECTOR: Chas. W. Faehlemann
ADDRESS: 703 Reisterstown

VS 151 4-20-88

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be furnished if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-450

BIRTH NO. 50 0398

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 Registered No. 50 0398

1. NAME OF DECEASED (Type or Print): MARY KLEIN

2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH: A. Baltimore City, Maryland 2478 Shirley Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Carmel Home

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1508 Poplar Grove St

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years. last birthday): 00 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aaron
14. MOTHER'S MAIDEN NAME: Yenta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Klein — ADDRESS: 1508 Poplar Grove St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1948 *to* Jan. 16, 1950, *that I last saw the deceased alive on* Jan. 14, 1950, *and that death occurred at* 7:25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul E. Cardenas M. D.
23B. ADDRESS: 2217 South Ave
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rosedale
24D. LOCATION (City, town, or county) (State): B Hamilton Ave & Phil. Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin, Inc., 2100-02 Eutaw Place
ADDRESS:

VS 150

0597 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Carlene
2217 Dorothy Road

A-256

50 0399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0399

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE ASNER

2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1520 Hollins St
C. Length of stay in Baltimore: 65 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 1520 Hollins St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 85 — If Under 1 Year: Months: Days: — If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Rugoff
14. MOTHER'S MAIDEN NAME: Beuhla
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leon Asner — ADDRESS: 1520 Hollins St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Ins. suffering

DUE TO

(B) Arteriolar Fibrillation.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 15 *, 195*0*, to* Jan 15 *, 195*0*, that I last saw the deceased alive on* Jan 15 *, 195*0*, and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Milton Sisonick M. D.
23B. ADDRESS: 1429 W Fayette St
23C. DATE SIGNED: Jan 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16-50
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county) (State): Wash Blvd.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. Levin Inc.
ADDRESS: 2100-02 Eutaw Place

VS 150

9213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ascovick
1429 N Fayette
Ft Scott

~~2215 Monroe~~
~~Ed 7711~~

F-460
50 0400

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0400
Registered No.

1. NAME OF DECEASED (Type or Print): Walter F. Fowler
2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 11-02
D. STREET ADDRESS (If rural, give location): 906 N. Charles St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec. 22, 1879
9. AGE (In years last birthday): 70 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Work
10B. KIND OF BUSINESS OR INDUSTRY: Mfg. Power Tools
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Marcellus Fowler
14. MOTHER'S MAIDEN NAME: Margaret Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Robert E. Fowler, son, ADDRESS 3706 Yolando Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post. Op. pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) carcinoma of right lung — over

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-12-50
19B. MAJOR FINDINGS OF OPERATION: Tumor Rt. Lung.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 14, 1950 *to* Jan 15, 1950 *that I last saw the deceased alive on* Jan. 15, 1950, *and that death occurred at* 3:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry E. Matthews M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: Jan 15 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Remington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150 26637

0-3-8-2

47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible].

Letter in document file. 50-0400 3/8/50.

T-614
50 0401
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

50 0401
Registered No.

1. NAME OF DECEASED (Type or Print): Hugh F. Triplett

2. DATE OF DEATH: JAN 14 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2625 Miles Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 8-27-70
9. AGE (In years last birthday): 79 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Station Engineer (Rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Stone Quarry
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dow Triplett
14. MOTHER'S MAIDEN NAME: Mary E. Gould

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular standstill due to unknown cause —
~~DUE TO~~
(B) Hypertensive cardiovascular disease
~~DUE TO~~
(C) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Squamous cell carcinoma rt. tonsil

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14, 1950, *to* 1-14, 1950, *that I last saw the deceased alive on* 1-14, 1950, *and that death occurred at* 7 3/4 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edyth H. Schweinler M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: St. Alphonsus Cem.
24D. LOCATION (City, town, or county) (State): Woodstock, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Wilson
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150 356 V6 0 4 0 0 45F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-520

50 0402

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-43

50 0402

Registered No.

1. NAME OF DECEASED (Type or Print): KATHERINE H. JONES

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2514 Guilford Ave.
C. Length of stay in Baltimore: 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2514 Guilford Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Feb. 12, 1873
9. AGE (In years last birthday): 76 yrs. If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Reimer Erbst
14. MOTHER'S MAIDEN NAME: -
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): - (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Louise Leonard - ADDRESS: 2514 Guilford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis. — INTERVAL BETWEEN ONSET AND DEATH: months?

DUE TO

ANTECEDENT CAUSES

(B) Chronic Hypertension — INTERVAL BETWEEN ONSET AND DEATH: "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) ✓

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 13, 1950, *to* Jan. 15, 1950, *that I last saw the deceased alive on* Jan. 15, 1950, *and that death occurred at* 9.30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank M. Ogden. M. D.
23B. ADDRESS: 2701 N. Calvert St.
23C. DATE SIGNED: Jan. 15, '50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

93D

H-620

50 0403
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420.1

Registered No. 50 0403

1. NAME OF DECEASED (Type or Print): Walter N. Harig - Sr.

2. DATE OF DEATH: Jan. 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3003 Shannon Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 30 - 1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traveling Commercial
10B. KIND OF BUSINESS OR INDUSTRY: Agent - Railway Express
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Harig
14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 712-14-8930
17. INFORMANT: Mrs Mildred A Harig
ADDRESS: 3003 Shannon Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Jan. 15, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Balt Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Lennington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford Rd

VS 154 200 48

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-562

50 0404
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

60 50 0404
Registered No.

1. NAME OF DECEASED (Type or Print): JOHN ROGER CONNORS

2. DATE OF DEATH: Jan 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 3301 Beverly Rd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 6-1902
9. AGE (In years last birthday): 47
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.P.O.
10B. KIND OF BUSINESS OR INDUSTRY: Rural
11. BIRTHPLACE (State or foreign country): Boston, Mass.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael H. Connors
14. MOTHER'S MAIDEN NAME: Julia O'Brien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Consuelo Connors
ADDRESS: 3301 Beverly

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage
DUE TO hypertension
(B) Diabetes mellitus
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/14/50 *19*, *to* 1/14/50 *19*, *that I last saw the deceased alive on* 1/14/50 *19*, *and that death occurred at* 5 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Maddeus Sliwinski M. D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard Huck
ADDRESS: 5305 Harford Rd.

VS 150
26695 0403 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-625

50 0405

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0405

1. NAME OF DECEASED (Type or Print): Joseph Arczynski (ARCZYNSKI)

2. DATE OF DEATH: Jan. 13 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 Fleet Street
C. Length of stay in Baltimore: 37 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1913 Fleet Street

2-03

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 14 1896
9. AGE (In years last birthday): 53 yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10B. KIND OF BUSINESS OR INDUSTRY: Furman Co.
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Arczynski
14. MOTHER'S MAIDEN NAME: Anna Orzechowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Aleksandra Arczynski — ADDRESS: 1913 Fleet Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis Lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

(B) "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Rapid Blood Loss — 1 yr

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Received

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 months, 19__, *to* Jan 13, 1950 *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* 5 P.A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Harris M.D.
23B. ADDRESS: 4902 Garrison Blvd
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17 50
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem
24D. LOCATION (City, town, or county) (State): Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: John W. Welby
ADDRESS: 401 S. Chester St.

VS 150

98850

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3901 Garrison Blvd.

K-500

BIRTH NO. 50 0406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 50 0406

1. NAME OF DECEASED (Type or Print): RAYMOND Kenney 181

2. DATE OF DEATH: 14 JAN 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Long Point
D. STREET ADDRESS (If rural, give location): % Pasedena Post Office

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: June 28, 1895
9. AGE (In years last birthday): 54 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce Dealer
10B. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Oliver Kenney
14. MOTHER'S MAIDEN NAME: KATE Hess
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Sally Adams ADDRESS: Church Home Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Papillary Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastases to lungs.

19A. DATE OF OPERATION: 1-13-50
19B. MAJOR FINDINGS OF OPERATION: Extensive carcinoma of bladder
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12, 1950 *to* 1-14, 1950 *that I last saw the deceased alive on* 1-14, 1950, *and that death occurred at* 9:50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lee M. Howard M. D.
23B. ADDRESS: Church Home + Hosp
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Phelps & Henry Sons
ADDRESS: 2029 Eutaw St

VS 150

15661

52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D-625

50 0407
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 no. 1

Registered No. 50 0407

1. NAME OF DECEASED (Type or Print): Norman N. Pearson

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6000 Glen Oak Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and the township): BALTO Md. 27-05
D. STREET ADDRESS (If rural, give location): 6000 Glen Oak Rd.

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Feb 3, 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED OFFICER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VALEGO CAL.
12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME: GUSTAVUS C.
14. MOTHER'S MAIDEN NAME: HARRIET BROWN.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS MARION E PEARSON
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congestive heart failure — 14 days

DUE TO

(C) Coronary sclerosis — 5 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1947, *to* Jan. 13, 1950, *that I last saw the deceased alive on* Jan. 12, 1950, *and that death occurred at* 4:17 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Donald Sandorf M. D.
23B. ADDRESS: 6077 Harford Rd
23C. DATE SIGNED: 1-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 17-50
24C. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT.
24D. LOCATION (City, town, or county) (State): ARLINGTON VA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: L. HEEMANN & SON
ADDRESS: 6067 HARF. Rd.

VS 150

1950 0406

11297

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-610

50 0408
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 no. 1

50 0408
Registered No.

1. NAME OF DECEASED (Type or Print): Rev. William A. Murphy

2. DATE OF DEATH: 1/13/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1546 N. Fremont St.
C. Length of stay in Baltimore: 7 yrs. (Yrs. ~~Mos.~~ ~~Days~~)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1546 N. Fremont St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: Mar 27, 1879
9. AGE (In years last birthday): 70 — If Under 1 Year: Months ; Days ; If Under 24 Hours: Hours ; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergyman
10B. KIND OF BUSINESS OR INDUSTRY: R.C. Priest
11. BIRTHPLACE (State or foreign country): Salem, Mass.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Murphy
14. MOTHER'S MAIDEN NAME: Johanna Mahoney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev. E. Casserly — ADDRESS: 1546 N. Fremont St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 3½ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CORONARY THROMBOSIS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1946 to Jan 13, 1950, that I last saw the deceased alive on Jan 8, 1950, and that death occurred at 5 P. m., from the causes and on the date stated above.

23A. SIGNATURE: E. William Frey, M. D.
23B. ADDRESS: 1928 Penna Ave
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Salem, Mass.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. Fanger & Sons — ADDRESS: 1827 W. North Ave.

VS 150

V0894

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-532

50 0409
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

581.0

50 0409
Registered No.

1. NAME OF DECEASED (Type or Print): PAUL PANTZER

2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: abt 23 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: ---
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 3307 Shelbourne Rd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: 4/15/90
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef
10B. KIND OF BUSINESS OR INDUSTRY: Miller Bros. Rest.
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Pantzer
14. MOTHER'S MAIDEN NAME: Antoinette Strodel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-07-3356
17. INFORMANT: A. J. Schmidt
ADDRESS: 967 Collington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock, irreversible, sec. to Gastrointestinal Hemorrhage, upper — Interval between onset and death: 16 hrs.

DUE TO

(B) Esophageal Varices

DUE TO

(C) Portal Cirrhosis of Liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Obesity; Hypertensive Cardiovascularenal Disease

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-14- *,* 1950 *, to* 1-15 *,* 1950 *, that I last saw the deceased alive on* 1-15 *,* 1950 *, and that death occurred at* 2:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Jaretesville Cem
24D. LOCATION (City, town, or county) (State): Jaretesville Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. A. Gray Sons
ADDRESS: 1318 Light St

VS 150

72071

124 B

(3307 Shelbourne RD)

PL-0409

S-326

STACHAROWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0410 — BIRTH NO.

Registered No. 50 0410

1. NAME OF DECEASED (Type or Print): Steven Stacharowski

2. DATE OF DEATH: January 14, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1926 Aliceanna Street
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03
D. STREET ADDRESS (If rural, give location): 1926 Aliceanna Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: November 30, 1892
9. AGE (In years last birthday): 57 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10B. KIND OF BUSINESS OR INDUSTRY: Tavern
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Simon Stacharowski
14. MOTHER'S MAIDEN NAME: Mary Gilewska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW I.
16. SOCIAL SECURITY NO.: 127-14-3588
17. INFORMANT: Mrs. Marie Stacharowski — ADDRESS: 3220 Belair Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* [signature] Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: M. F. Sadowski & Sons — ADDRESS: 1808 Eastern Avenue

VS 151

7071 — 0 4 0 — 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-240

50 0411

BIRTH NO. 49-28410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

76115

50 0411 Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL ZIEGEL 774

2. DATE OF DEATH: Jan 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital
C. Length of stay in Baltimore: 16 Days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-02
D. STREET ADDRESS (If rural, give location): 1521 Lakeside Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): INFANT
8. DATE OF BIRTH: Dec 30, 1949
9. AGE (In years last birthday): If Under 1 Year: Months: Days: 16; If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): St Joseph's Hospital, Balt., Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adams Benjamin
14. MOTHER'S MAIDEN NAME: Concetta Munafo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Premature Separation of Placenta
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Baby weighed only 864 grams at Birth

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Dec 30, 1949, *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 15, 1950, *and that death occurred at* 8:06 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Vito L Coppa M. D.
23B. ADDRESS: St Joseph's Hospital
23C. DATE SIGNED: Jan 15, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-1950
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL CEM.
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd Balt, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Lawrence Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Rocca
ADDRESS: 322 S. High St.

VS 150

50 0410

160C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-656 Med Exam Room
50 0412 Med. Exam Case
Released to Hosp.

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 Registered No. 50 0412

1. NAME OF DECEASED (Type or Print): Gertrude M. Brunner

2. DATE OF DEATH: Jan. 15, '50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-03
D. STREET ADDRESS (If rural, give location): 1636 Clarkson St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: AUG 2 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months 5, Days 13 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: ALPHONSE TRUFFER
14. MOTHER'S MAIDEN NAME: SUSANA SAMALINSKA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH: 2 yr
DUE TO Inoperable

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 15, 1950 *to* Jan 15, 1950 *that I last saw the deceased alive on* Jan 15, 1950 *and that death occurred at* 11 15 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Duane J Merrill M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN-19-50
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM
24D. LOCATION (City, town, or county) (State): A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bernard E. Harle — ADDRESS: 121 E West St

VS 150

To be approv. by Med Exam

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and concisely.

NOT A MEDICAL EXAMINER'S CASE

R S Fisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER

5-3 165

50 0413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1720.0 50 0413

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or print): Edwin Sternberger Sternberger

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital Sinai Hospital

C. Length of stay in Baltimore: 50 Years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE B. COUNTY Riviera Apt, Balto, Md,

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md, 13-01

D. STREET ADDRESS (If rural, give location): Riviera Apt, Linden, Ave, bBalto, M

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June, 8, 1877.

9. AGE (In years last birthday): 72

If Under 1 Year: Months 7 Days 8

If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Credit Manger

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Sternberger

14. MOTHER'S MAIDEN NAME: Francisco.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT: Mrs. Ella Sternberger ADDRESS: Riviera, Apt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis c myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 wks

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic Heart Disease — 4 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/24, 1949 *to* 1/15, 1950, *that I last saw the deceased alive on* 1/15, 1950, *and that death occurred at* 10:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leon E Kanel M. D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 1/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 17, 1950

24C. NAME OF CEMETERY OR CREMATORY: Balto Hebrew Cemetery

24D. LOCATION (City, town, or county) (State): Belair Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950

REGISTRAR'S SIGNATURE: Emily Jon Williams M.D.

25. FUNERAL DIRECTOR: David Sondheim & Son

ADDRESS: David Sondheim & Son 1902 Eutaw Place

12483

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

W- 340

50 0414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 1 50 0414

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Royal Wheatley also known as Roy

2. DATE OF DEATH: Jan 15 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1917 Jefferson St

C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore C-04
D. STREET ADDRESS (If rural, give location): 1917 Jefferson St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 30 1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe mill
10B. KIND OF BUSINESS OR INDUSTRY: Beth Steel
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John W. Wheatley
14. MOTHER'S MAIDEN NAME: Mary Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Wheatley
ADDRESS: 1917 Jefferson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Rheumatoid Arthritis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2, 1950, to Jan 15, 1950, that I last saw the deceased alive on 1/14, 1950, and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE: Charles Tomm M. D.
23B. ADDRESS: 3123 Eastern Ave
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or County) (State): Colgate, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Martin L. Williams M.D.
25. FUNERAL DIRECTOR: Ulrich Funeral Home
ADDRESS: 2008 Orleans St.

VS 150

49629 CHARLES FIOM 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

F 436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0415 Registered No. 50 0415

1. NAME OF DECEASED (Type or Print): EDWARD J. FOLDERAUER

2. DATE OF DEATH: 1-14-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 502 E. BARNEY ST
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 24-04
D. STREET ADDRESS (If rural, give location): 502 E BARNEY ST

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 3-14-1917
9. AGE (In years last birthday): 32
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY: NEVER WORKED
11. BIRTHPLACE (State or foreign country): BALTO.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GODFREY FOLDERAUER
14. MOTHER'S MAIDEN NAME: GRACE JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): WORLD WAR II
16. SOCIAL SECURITY NO.:
17. INFORMANT: AGNES FOLDERAUER
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO Bilateral, severe
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 19 49, *to* Jan. 19 50, *that I last saw the deceased alive on* 1/14, 19 50, *and that death occurred at* D *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. Kleeson M. D.
23B. ADDRESS: 102 E. West St
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-50
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.
24D. LOCATION (City, town, or county) (State): A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles F. Dill
ADDRESS: 1501 E. Fort Ave

VS 150

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-212

50 0416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-20-1

Registered No. 50 0416

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George W Jacobs

2. DATE OF DEATH: January 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 826 Chauncey Ave
C. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 826 Chauncey Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 26 1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months: 4 Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor Of Move
10B. KIND OF BUSINESS OR INDUSTRY: Theatre
11. BIRTHPLACE (State or foreign country): Rome New York
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Julius Jacobs
14. MOTHER'S MAIDEN NAME: Margaret Singer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Rose Jacobs
ADDRESS: 826 Chauncey Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: ~
19B. MAJOR FINDINGS OF OPERATION: ~
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ~
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ~
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ~

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ~
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: ~

22. *I hereby certify that I attended the deceased from* January 11, 1950, *to* January 16, 1950, *that I last saw the deceased alive on* Jan 16, 1950, *and that death occurred at* 1:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Kadow M. D.
23B. ADDRESS: 2306 Eutaw Pl Balto Md
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan, 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Ernestine Lots Williams M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

1569V 0415 94a

F452

AB-134848

CERTIFICATE CORRECTED 1-16-1950

BIRTH NO. 50 0417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0417

1. NAME OF DECEASED (Type or Print): William Randal Flanagan

2. DATE OF DEATH: Jan. 15-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 610 W. Mosher Street

5. SEX: M
6. COLOR OR RACE: N
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 24- ~~1907~~ 1909
9. AGE (In years last birthday): 43 40
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARTENDER
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Flanagan
14. MOTHER'S MAIDEN NAME: Charity Barber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10- *,* 1950 *, to* 1-15- *,* 1950 *, that I last saw the deceased alive on* 1-15- 1950 *, and that death occurred at* 3.10 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: P. L. Chapin M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 1-16-1950

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 1-18-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr.
ADDRESS: 1011 W. Arlington Ave.

VS 150
71071

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

N-240

50 0418

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4/20.1

50 0418

Registered No.

1. NAME OF DECEASED (Type or Print): George A. Michael

2. DATE OF DEATH: 1-14-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1001 Abbott Ct.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-00
D. STREET ADDRESS (If rural, give location): 1001 Abbott Court

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 7, 1886
9. AGE (In years last birthday): 63 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Michael Michael
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 212-05-4434
17. INFORMANT: Wynona Michael — ADDRESS: 1001 Abbott Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 day

DUE TO

(B) Myocardial Infarction — 1 year

DUE TO

(C) Hypertensive Cardio Vasc. Disease — 10 "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1947 *to* Jan, 1950 *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 7:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Friedman M. D.
23B. ADDRESS: 404 E. North Ave
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: John C. Miller Inc. — ADDRESS: 2435 E. Olive St.

VS 150 34859

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-520

Kinch

50 0419

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

204.0

50 0419

Registered No.

1. NAME OF DECEASED (Type or Print): Kinch, Mr. Lambert Blair

2. DATE OF DEATH: Jan 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.
C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 4220 Loch Raven Blvd.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 3, 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank H. Kinch
14. MOTHER'S MAIDEN NAME: Lillie Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 578-03-9312
17. INFORMANT: Lambert Kinch — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphoid Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 yr

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 12, 1950, *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 15, 1950 *and that death occurred at* 5:0 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mary E. Mathews M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: Jan 15 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18/50
24C. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
24D. LOCATION (City, town, or county) (State): York, Penna.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. — ADDRESS: 108 W. North Ave.

VS 150

74a City #1.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and concisely.

MARGIN RESERVED FOR BINDING

W-325

50 0420

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44

50 0420

Registered No.

1. NAME OF DECEASED (Type or Print): ANNA MARGARET WEDEKIND

2. DATE OF DEATH: JAN. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2822 PRESSTMAN ST.
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 16-07
D. STREET ADDRESS (If rural, give location): 2822 PRESSTMAN ST.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: MAR. 11, 1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OPERATOR-SEWING
10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING MFG.
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN A. WEDEKIND
14. MOTHER'S MAIDEN NAME: MARGARET RICE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 212-03-8841
17. INFORMANT: MRS. MARY DONOHUE
ADDRESS: 2822 PRESSTMAN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 30 hours

DUE TO

(B) Interstitial Cardio-vascular-renal Disease — ?

DUE TO

(C) Paralysis Agitans — 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. *, 19* 49 *to* Jan. 13 *, 19* 50 *, that I last saw the deceased alive on* Jan. 13 *, 19* 50 *, and that death occurred at* 6-30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: A. A. Freeman M. D.
23B. ADDRESS: 1109 N. Calvert St
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: John H. Moran
ADDRESS: 3000 E. Balto. St. Balto 24, Md.

VS 150 49606

131a

B-530

50 0421
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

2-60

50 0421
Registered No.

1. NAME OF DECEASED (Type or Print): Mary Cecelia Bennett,

2. DATE OF DEATH: JAN 15 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4626 Pall Mall Road,
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 27-16
D. STREET ADDRESS (If rural, give location): 4626 Pall Mall Road,

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 9, 1883
9. AGE (In years last birthday): 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James H. Larkins,
14. MOTHER'S MAIDEN NAME: Mary Rochford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Charles G. Bennett, ADDRESS: 4626 Pall Mall Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Calculi — INTERVAL BETWEEN ONSET AND DEATH: 6-4-49

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diabetes Mellitus — 2 yr

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 4, 1949 *to* Jan. 15, 1950, *that I last saw the deceased alive on* Jan. 15, 1950, *and that death occurred at* 2.05 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alex D Bubert M. D.
23B. ADDRESS: 4803 Park Heights Ave.
23C. DATE SIGNED: JAN 16 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Jan. 19, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Sherman Lemmon
ADDRESS: 4611 Park Heights Ave.

VS 150

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 400

BIRTH NO. 50 0422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H 20.1

Registered No. 50 0422

1. NAME OF DECEASED (Type or Print): Mary C. (or Mamie C.) Zell

2. DATE OF DEATH: JAN 14 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3118 Woodland Ave.,
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 27-17
D. STREET ADDRESS (If rural, give location): 3118 Woodland Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Sept.8,1883
9. AGE (In years last birthday): 66
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10B. KIND OF BUSINESS OR INDUSTRY: Movie Theatre
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William H. Michael,
14. MOTHER'S MAIDEN NAME: Ammie Presley,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-07-1219
17. INFORMANT: Mr. F. X. Zell, ADDRESS: 3118 Woodland Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: 12-21-48
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 21, 1948, *to* Jan. 14, 1950 *that I last saw the deceased alive on* Jan. 14, 1950, *and that death occurred at* 7.15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thos D Beckett M. D.
23B. ADDRESS: 4803 Park Heights Ave.,
23C. DATE SIGNED: JAN 16 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Jan. 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: S. Kenny Livingston
ADDRESS: 4611 Park Heights Ave.

VS 150 2109V 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-350
50 0423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

58 1.0 50 0423

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry J. Wooden

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 1600 Linden Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1600 Linden Ave 14-1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug 21 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason
10B. KIND OF BUSINESS OR INDUSTRY: Stone, Seller Retired
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Thos. C. Wooden
14. MOTHER'S MAIDEN NAME: Catherine M. Kenney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev Roger Wooden
ADDRESS: Hamburg 775 W. St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

ANTECEDENT CAUSES

(B) Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Liver-Cirrhosis Myocardial

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Heart-Insufficiency

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1948 *to* January, 1950 *that I last saw the deceased alive on* January 7, 1950 *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: K. Traugott M. D.
23B. ADDRESS: 1623 E. N. Avenue
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Roland Wiedefeld
ADDRESS: 905 E. Biddle St.

VS 150
306 V9

Cath Dr Traugott 1623 E. North Ave 124B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

S-633

50 0424

SWARTWOUT

1 50 0424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A Swartwout

2. DATE OF DEATH: Jan. 14. 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 700 Springfield Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 011

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 700 Springfield Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec 20 1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: D. of Pub Welfare
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME: Joshua F Sindall
14. MOTHER'S MAIDEN NAME: Sophie O'Brien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paroxysmal Ventricular Tachycardia — INTERVAL BETWEEN ONSET AND DEATH: 3 Min.

DUE TO

(B) Coronary thrombosis — 6 yrs.

DUE TO

(C) Myocardial Degeneration — 6 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1945, *to* Jan 14, 1950, *that I last saw the deceased alive on* Jan 13, 1950, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leland F O'Donnell M. D.
23B. ADDRESS: 7301 York Rd
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 18, 1950
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Govans
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: JAN 16 1950
REGISTRAR'S SIGNATURE: Municipal Registrar
25. FUNERAL DIRECTOR: Bela Wiedefeld
ADDRESS: 9006 Beddle St

VS 150 116 98

St Mary's - Dr Chas J Pommer 93D 6000 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible]

500

50 0425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

50 0425

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA LEWIN

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5204 Greenwich Ave.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 5204 Greenwich Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 1868
9. AGE (In years last birthday): 81
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At. Home
11. BIRTHPLACE (State or foreign country): Bonn, Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (Unknown) Wolff
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Leo Eckert, 5204 Greenwich Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-

DUE TO

(C) Vascular Disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 19, 1949, *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 15, 1950, *and that death occurred at* 7 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: A. H. Carnathan M. D.
23B. ADDRESS: 4709 Fend. Ave
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: N. Y. & N. J. Crematorium N. Bergan
24D. LOCATION (City, town, or county) (State): N. Bergan, N.J.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc.
ADDRESS: 1217 St. Paul St.

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50 0427

50 0427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Paul Dunn.

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 448 Pittmon Place

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct 10. 1906
9. AGE (In years last birthday): 43
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEVER WORKED
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul Dunn
14. MOTHER'S MAIDEN NAME: Mary A Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Paul Dunn
ADDRESS: 448 Pittmon Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 12-22-49-1-16-50

DUE TO

ANTECEDENT CAUSES

(B) Chronic Glomerular Nephritis — (?)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Rheumatic Heart Disease, Hypertension

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 22, 1949, *to* Jan. 16, 1950, *that I last saw the deceased alive on* Jan. 16, 1950, *and that death occurred at* 2.30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Clifford E. Riddel Jr. M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Thurlington Williams M.D.
25. FUNERAL DIRECTOR: Williams & Co Inc
ADDRESS: 1317 E Pratt St

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

R-1000

50 0426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17°

50 0426

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MABEL A. ROWE

2. DATE OF DEATH: Jan.15,1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2430 Annor Court,
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2430 Annor Court

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated
8. DATE OF BIRTH: July 4,1885
9. AGE (In years last birthday): 64 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At. Home
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William W. Collison
14. MOTHER'S MAIDEN NAME: Helen Glenn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs H.F.Collins, ADDRESS: 2403 Dumfries Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Ca. oveg[illegible]
DUE TO Sum Breast Ca. removed 1944 — INTERVAL BETWEEN ONSET AND DEATH: 1 year.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO Hypertension C.V.D — 3 year
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1944
19B. MAJOR FINDINGS OF OPERATION: Ca. Breast left -
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov-10, 1949 *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 15, 1950 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Schofield M. D.
23B. ADDRESS: 2301 Annapolis Rd
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

VS 150

0426

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H. 400 50 0428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H no. 1 50 0428

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Roy HALL

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4519 Mannasota Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: March 4, 1909
9. AGE (In years last birthday): 40 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RADIO Student TECHNICIAN
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Radio School

11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Hall
14. MOTHER'S MAIDEN NAME: Mary F. White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Earlie M. Hall — ADDRESS: Burlington, N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Earl L Rogers M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Mayodam Cem.
24D. LOCATION (City, town, or county) (State): Madison, N.C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Martha Jane Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM COOK, INC., 1217 St. Paul St.
ADDRESS

VS 151

33635 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H 520

50 0429

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20.0

50 0429

Registered No.

1. NAME OF DECEASED (Type or Print): WALTER M. HINKEY

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 804 Cathedral St.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 106 W. University Pkwy.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 30, 1889
9. AGE (In years last birthday): 60 yrs. — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber Agt.
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): A. A. Co.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin E. Hinkey
14. MOTHER'S MAIDEN NAME: Sarah A. Stockett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Rose Hinkey — ADDRESS: 106 W. University Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs+

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/23, 1949, *to* 1/13, 1950, *that I last saw the deceased alive on* 12/26, 1949, *and that death occurred at* 1:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: C Edward Leach, M. D.
23B. ADDRESS: 14 E. Eager St.
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150 98847 50 0428 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

B-600

456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0430

Registered No. 50 0430

1. NAME OF DECEASED (Type or Print): Katherine E. Bauer

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 2908 Winchester St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 10-6-89
9. AGE (In years last birthday): 60
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lewis Rauschenbach
14. MOTHER'S MAIDEN NAME: Emma Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Lupus erythematosis disseminata — 3½ yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/6/15, 1949, *to* 1/16, 1950, *that I last saw the deceased alive on* 1/16, 1950, *and that death occurred at* 2:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ernest C. Brown Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

50 0431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

334

50 0431 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James A. Griffin

2. DATE OF DEATH: 15 Jan 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore 31 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 6205 Pinehurst Rd.

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 28, 1885
9. AGE (In years last birthday): 64 yrs. If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. & Factory Mgr.
10B. KIND OF BUSINESS OR INDUSTRY: Fertilizer
11. BIRTHPLACE (State or foreign country): Wash., D. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Griffin
14. MOTHER'S MAIDEN NAME: Ida E. Fuggitt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-03-0550
17. INFORMANT: Mr. James A. Griffin, Jr. ADDRESS: 500 Alabama Rd. Towson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic subdural hematoma, right

DUE TO (B) Mild bodily trauma (landing on buttocks) No injuries

DUE TO Severe cerebral arteriosclerosis

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

Earl Ryan M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 14 + 15 Jan 1950
19B. MAJOR FINDINGS OF OPERATION: Chronic subdural hematoma, right. cerebral atherosclerosis
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 6205 Pinehurst Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 1, 1950 (?) ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Went to sit on a chair, slipped and fell to the floor.

22. *I hereby certify that I attended the deceased from* 13 Jan *1950, to* 15 Jan *1950, that I last saw the deceased alive on* 15 Jan *1950, and that death occurred at* 11:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jose A. Alvarez-de Choudens M.D. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 16 Jan 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.
24D. LOCATION (City, town, or county) (State): Washington, D. C.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150 50 0430

156 17 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 50 0432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0432

1. NAME OF DECEASED (Type or Print): JACOB FREDERICK GRAY

2. DATE OF DEATH: January 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1631 E. Lanvale Street
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1631 E. Lanvale Street

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr. 12, 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Estimator
10B. KIND OF BUSINESS OR INDUSTRY: Monumental Carpet Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Gray
14. MOTHER'S MAIDEN NAME: Caroline Scherr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-8678
17. INFORMANT: Mrs. Minnie Gray 1631 E. Lanvale Street (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Myocarditis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 30, 1949, *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 15, 1950, *and that death occurred at* 3.30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jacob Fisher M. D.
23B. ADDRESS: 1823 N. Wash. St.
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150 26688 0431 93D

S-353

BIRTH NO. 50 0433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

351

Registered No. 50 0433

1. NAME OF DECEASED (Type or Print): LAURA THOMAS STEINMETZ

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3318 Lyndale Avenue
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3318 Lyndale Avenue

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 22, 1922
9. AGE (In years last birthday): 27
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Steinmetz
14. MOTHER'S MAIDEN NAME: Laura V. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 3318 Lyndale Avenue - 13
Mrs. Laura V. Steinmetz

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Idiopathic Epilepsy & Spastic Paraplegia & mental retardation since birth — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(C) Cerebral birth injury — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 12, 1950 *to* Jan 16, 1950, *that I last saw the deceased alive on* Jan 12 1950, *and that death occurred at* 12:01 AM *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 3400 Eutaw Ave.
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Schwartz Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150

87E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

163

50 0434

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 20 1

50 0434 Registered No.

1. NAME OF DECEASED (Type or Print): HARRY NEWTON ROBERTS

2. DATE OF DEATH: 1/14/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 7-02
D. STREET ADDRESS (If rural, give location): 1504 Lakeside Ave # 18

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 3/31/82
9. AGE (In years last birthday): 67
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retsecretary official
10B. KIND OF BUSINESS OR INDUSTRY: H. B. Davis Paint Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Newton Roberts
14. MOTHER'S MAIDEN NAME: Minnie May Ress

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-1384
17. INFORMANT: Mrs. Rose L. Roberts ADDRESS: 1504 Lakeside Avenue -18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Hypertension Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebrovascular accident

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/26, 1950 to 1/14, 1950 that I last saw the deceased alive on 1/14, 1950 and that death occurred at 5:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Charles J. Black M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-18-50
24C. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

VS 150 23615

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

A-2 CERTIFICATE CORRECTED 1-31-50 50 0435

50 0435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 32

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTHA E. ASHBY

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2538 McCulloh Street
C. Length of stay in Baltimore: 2½ yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2538 McCulloh Street

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 15, 1895
9. AGE (In years last birthday): ~~54~~ 55 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James R. Butler
14. MOTHER'S MAIDEN NAME: Eliza Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ~~Mrs. Harvey~~ Mrs. Florence E. Johnson — ADDRESS: 2538 McCulloh Stre

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO arteriosclerosis + Hypertension.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Nephritis — 1 month

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1949, *to* 1-15, 1950, *that I last saw the deceased alive on* 1-15-, 1950, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 2224 Madison Av.
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/1950
24C. NAME OF CEMETERY OR CREMATORY: White Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Asbury Park, N.J.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 01631 Druid Hill Ave.

VS 150

52086 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

S-363

50 0436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0436

Registered No. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Stewart / STEWART

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 2006 Pressman St.

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 23, 1880
9. AGE (In years last birthday): 69 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): Howard Co. Md
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Matthew Stewart
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 d.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension and Arteriosclerosis — 7 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetic Acidosis — 5-2d.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-13, 1950 *to* 1-13, 1950 *that I last saw the deceased alive on* 1-13, 1950, *and that death occurred at* 11:40 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Sukeens M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 17, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 0 Reisterstown Ave.

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50 0437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002

50 0437

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RUTH MIMS ANDERSON

2. DATE OF DEATH: Jan. 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1410 Argyle Ave.
C. Length of stay in Baltimore: 21 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-07
D. STREET ADDRESS (If rural, give location): 1410 Argyle Ave.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 3, 1928
9. AGE (In years last birthday): 21 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine operator
10B. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Rutherford Mims
14. MOTHER'S MAIDEN NAME: Edith Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Elizabeth Mims — ADDRESS: 1410 Argyle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-4, 1950 *to* 1-13, 1950 *that I last saw the deceased alive on* 1-12, 1950 *and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Atwell Jones M. D.
23B. ADDRESS: 5-5-4 Dolphin St.
23C. DATE SIGNED: 1-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 18, 1950
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1621 Druid Hill Ave.

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13B

50 0438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0438

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ZACHARIAH HOWE

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1130 W. Lafayette Ave.
c. Length of stay in Baltimore: 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 16 01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1130 W. Lafayette Ave.

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: April 7, 1860
9. AGE (In years last birthday): 89
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY: Restuarant
11. BIRTHPLACE (State or foreign country): Calvert Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dennis Howe
14. MOTHER'S MAIDEN NAME: Julia Rollins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Margaret Howe
ADDRESS: 1130 Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteria-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

ANTECEDENT CAUSES

(B) " " "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Senility —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

"

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10, 1950 *to* 1-15, 1950 *that I last saw the deceased alive on* 1-14, 1950 *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. P. Hughes M. D.
23B. ADDRESS: 825 N. Fremont Ave
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Annette Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

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B-200-

50 0439

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443

Registered No. 50 0439

1. NAME OF DECEASED (Type or Print): Edith Bell Beck

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 213 Oakdale Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none
C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 213 Oakdale Road

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Nov. 15, 1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: David Bell
14. MOTHER'S MAIDEN NAME: Mary A. Bersch
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret B. Beck — ADDRESS: 213 Oakdale Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular — INTERVAL BETWEEN ONSET AND DEATH: 1-8 years

DUE TO

ANTECEDENT CAUSES

(B) Hypertension + arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1940, 19__, *to* 1/15, 1950, *that I last saw the deceased alive on* 1/15, 1950, *and that death occurred at* 3 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry D. McCarty M. D.
23B. ADDRESS: 37 W. Preston St.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1 - 18 - 50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. — ADDRESS: 1900 Eutaw Pl.
Walton B. Mitchell

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E-520

50 0440

Linie

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 1

50 0440

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eing, Charles D.

2. DATE OF DEATH: Jan. 14, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-086
D. STREET ADDRESS (If rural, give location): 5508 Midwood Ave.

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 7, 1892

9. AGE (In years last birthday): 58

If Under 1 Year: Months | Days

If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Standard Oil Co.

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John P. Eing

14. MOTHER'S MAIDEN NAME: Ellen Mary Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Patient ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 14, 1950 *to* Jan 14, 1950, *that I last saw the deceased alive on* Jan 14, 1950 *and that death occurred at* 5:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mary E. Mathews M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: Jan 14 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 19 50

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950

REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.

25. FUNERAL DIRECTOR: John C. Moran

ADDRESS: 3000 Raleigh St

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-510

50 0441

CERTIFICATE CORRECTED 1-25-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0441

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose V. Schempp

2. DATE OF DEATH: Jan 15 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2700 Doctors Hospital Charles St

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: 3098 Robinson

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 1-02

D. STREET ADDRESS (If rural, give location): 3098 Robinson St

5. SEX: Fem

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify): Married

8. DATE OF BIRTH: April 14 1874

9. AGE (In years last birthday): 75 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Callahan

14. MOTHER'S MAIDEN NAME: Mary Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Elmer Elmer L Schempp — ADDRESS: 2729 Beryle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-13, 1950, *to* 1-15, 1950, *that I last saw the deceased alive on* 1-15, 1950, *and that death occurred at* 3:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: William H. Fursting M. D.

23B. ADDRESS: 11 E. Chase St

23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 19 1950

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950

REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.

25. FUNERAL DIRECTOR: John A. Moran

ADDRESS: 3000 E Baltimore St

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50 0442

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

741

50 0442

Registered No.

1. NAME OF DECEASED (Type or Print): John B. Poe.

2. DATE OF DEATH: 1/15/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3640 Beech Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 3640 Beech Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 11/10/1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10B. KIND OF BUSINESS OR INDUSTRY: Locke Insulator
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mahlon L. Poe
14. MOTHER'S MAIDEN NAME: Ida Ambrose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-05-6075
17. INFORMANT: Ethel B Harding
ADDRESS: 3640 Beech Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Myocardial Failure — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Bronchial Asthma Chronic — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 3, 1949, *to* 1-15, 1950, *that I last saw the deceased alive on* 1-15, 1950, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lawrence J. Armanti M. D.
23B. ADDRESS: 3711 Falls Rd
23C. DATE SIGNED: 1-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's
24D. LOCATION (City, town, or county) (State): Hampden.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Paul L. Lehnert Jr.
ADDRESS: 3615 N. Chestnut Ave.

VS 150

73035

112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-410

50 0443
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0443

1. NAME OF DECEASED (Type or Print): Caroline Kalb

2. DATE OF DEATH: JAN 16. 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland St Agnes.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Catonsville
D. STREET ADDRESS (If rural, give location): 101 Fairfield Drive

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2-16-1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore Kromm.
14. MOTHER'S MAIDEN NAME: Catherine Sharman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: WILLIAM KALB
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE
DUE TO
(B) HYPERTENSIVE ARTERIOSCLEROSIS
DUE TO CARDIOVASCULAR DISEASE
C CONGESTIVE FAILURE
(C) DIABETES MELLITUS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/2, 1950, *to* 1/16, 1950, *that I last saw the deceased alive on* 1/16, 1950, *and that death occurred at* 10:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: [illegible]
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: MacNabb & Sons
ADDRESS: Catonsville 28

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M-R 40

50 0444

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0444

1. NAME OF DECEASED (Type or Print): Howard W. McCall N854.0

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland E81.4
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ RURAL
D. STREET ADDRESS (If rural, give location): 7653 Old Battlegrove Rd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAY 6, 1883
9. AGE (In years last birthday): 66 yrs. If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UPHOLSTERER
10B. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM McCALL
14. MOTHER'S MAIDEN NAME: MARY VIRGINIA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. VIRGINIA L. McCALL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion brainstem
~~DUE TO~~ Sub arachnoid hemorrhage
(B) Fracture, left femur
DUE TO Fracture, ribs multiple
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Point Rd. near Mathai Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 16, 1950 6:30 Pm.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [X], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: JAN 19, 1950
24C. NAME OF CEMETERY OR CREMATORY: PARKWOOD CEM.
24D. LOCATION (City, town, or county) (State): BALTO. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Rolandy L. Fisher ADDRESS: Dundalk Md

VS 151

36495 170C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-145

50 0445
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

50 0445
Registered No.

1. NAME OF DECEASED (Type or Print): Blanche J. Le Blanc

2. DATE OF DEATH: 1-16-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3612 Elmley Ave
C. Length of stay in Baltimore: 45 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 26-03
D. STREET ADDRESS (If rural, give location): 3612 Elmley Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 17-1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Neopolian La Montague
14. MOTHER'S MAIDEN NAME: Annie La Rush

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr. Augustin Le Blanc
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of Liver.
DUE TO
(B) Adeno Carcinoma of Colon.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: About 1½ years ago.
19B. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of Colon.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Jan 16, 1950, *that I last saw the deceased alive on* Jan 15, 1950, *and that death occurred at* 6:00 AM *from the causes and on the date stated above.*

23A. SIGNATURE: L B Stevens M. D.
23B. ADDRESS: 3400 Eastman Ave
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-50
24C. NAME OF CEMETERY OR CREMATORY: Bel Air Mem Gardens
24D. LOCATION (City, town, or county) (State): Bel Air Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos J Iter & Son
ADDRESS: 3001 Kentucky Ave #13

VS 150

46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1949
64
1885

C-656

50 0446
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0446

1. NAME OF DECEASED (Type or Print): JOHN THOMAS CREAMER

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: 48 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockville
D. STREET ADDRESS (If rural, give location): 320 Grandin Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/17/85
9. AGE (In years last birthday): 64
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab. Technician
10B. KIND OF BUSINESS OR INDUSTRY: NHI-Bethesda, Md.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Creamer
14. MOTHER'S MAIDEN NAME: Emma Offutt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-20-2493
17. INFORMANT: Records- US Marine Hospital, Balto, Md.
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Pneumonia, lobular, left lower lobe	Less than 1 wk.
DUE TO		
ANTECEDENT CAUSES		2 wks.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Thrombosis, cerebral, right	
DUE TO		4 mos.
	(C) Tuberculosis, pulmonary, right upper lobe	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Myelosclerosis	Unknown

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 30, 1949, *to* Jan. 17, 1950, *that I last saw the deceased alive on* Jan. 17, 1950, *and that death occurred at* 5:05A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/17/50
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Bethesda - Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Robert Pumphrey - Bethesda
ADDRESS

Vs 150

V709v

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

S-126

50 0447

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 10

Registered No. 50 0447

1. NAME OF DECEASED (Type or Print): Joseph H. Spicer

2. DATE OF DEATH: January 15, 195

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I444 Decatur St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 24-01
D. STREET ADDRESS (If rural, give location): Decatur St. I444

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: I2/28/I866
9. AGE (In years last birthday): 83
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10B. KIND OF BUSINESS OR INDUSTRY: Wood Worker
11. BIRTHPLACE (State or foreign country): Deleware
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 2I2-I6-3349
17. INFORMANT: Joseph G. Spicer I444 Decatur St.
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Phlebitis of left leg — 6 weeks

DUE TO

(C) Postoperative Prostatectomy — 6 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1945, *to* Jan 15, 1950, *that I last saw the deceased alive on* Jan 14, 1950, *and that death occurred at* 8P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Lehn Field M. D.
23B. ADDRESS: 1301 Annapolis Rd
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: I/I9/I950
24C. NAME OF CEMETERY OR CREMATORY: Georgetown Cemetery
24D. LOCATION (City, town, or county) (State): Georgetown, Deleware.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: Flynn & Fleming, I426 Light St.
ADDRESS

Vs 150

988 10

137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

T-520

50 0448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

445

Registered No. 50 0448

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Melissa Jones

2. DATE OF DEATH: Jan. 14-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
D. STREET ADDRESS (If rural, give location): 625 N. Caroline St.

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 4-21-1902
9. AGE (In years last birthday): 47
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Graney Owens
14. MOTHER'S MAIDEN NAME: Frances Randel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry Jones — above
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO

ANTECEDENT CAUSES

(B) Nephrosclerosis — 1 yr. at least.

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Malignant ess. hypertension — over 1 yr.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

No.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Dec., 1949 *to* 14 Jan., 1950 *that I last saw the deceased alive on* Jan. 14, 1950, *and that death occurred at* 11:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M.D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18/50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A A County Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Mrs Robert A. Elliott & Daughter
ADDRESS: 1129 N. Caroline St

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 252

BIRTH NO. 50 0449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4 20.0

Registered No. 50 0449

1. NAME OF DECEASED (Type or Print): Silas (Cyrus) Sackine

2. DATE OF DEATH: Jan. 15 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1635 Ashland Ave.
C. Length of stay in Baltimore: 39 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 7-05
D. STREET ADDRESS (If rural, give location): 1635 Ashland Ave

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov 11, 1904
9. AGE (In years last birthday): 45 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: The Atlantic Transportation
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dennis Sackine
14. MOTHER'S MAIDEN NAME: Eliza ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give wer or dates of service)
16. SOCIAL SECURITY NO.: 216-12-2991
17. INFORMANT: Estella Crosson — ADDRESS: 1635 Ashland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: ? unk.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-26, 1949 to 1-15, 1950, that I last saw the deceased alive on 1-12, 1950 and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE: [signature]
RAYNER BROWNING
1500 EAST MADISON ST.
BALTIMORE 5, MD.
23B. 10:30 A.M.
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 19 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): A. A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [signature] Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: Mrs. Robert A. Elliott & Daughter
ADDRESS: 1129 N. Caroline St.

VS 150

98851 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-450

50 0450
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490

Registered No. 50 0450

1. NAME OF DECEASED (Type or Print): Vandorn Mullen

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1521 Brady Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-06
D. STREET ADDRESS (If rural, give location): 1521 Brady Avenue

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug 30-1908
9. AGE (In years last birthday): 51
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): N C
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Mullen
14. MOTHER'S MAIDEN NAME: Martha Peace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Mullen
ADDRESS: 1521 Brady Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 10, 1950, *to* Jan. 14, 1950 *that I last saw the deceased alive on* Jan. 14, 1950 *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Renold B Higgins M.D.
23B. ADDRESS: 501 Cherry Hill Road
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 18-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Mortimer Williams, M.D.
25. FUNERAL DIRECTOR: Robert E. Williams
ADDRESS: 1515 N. Eldon St

VS 150

98 44

108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-552

50 0451
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 ✓ Registered No. 50 0451

1. NAME OF DECEASED (Type or Print): Charles F. Schiminsky
2. DATE OF DEATH: 1/17/50
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hospital
C. Length of stay in Baltimore: Yrs. Life Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3810 Elmley Avenue
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: July 31 - 1919
9. AGE (In years last birthday): 30
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech. Eng.
10B. KIND OF BUSINESS OR INDUSTRY: Mathieson Bldg
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Felix Schiminsky
14. MOTHER'S MAIDEN NAME: Julia Magan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-07-4632
17. INFORMANT: Mrs. Schiminsky
ADDRESS: 3810 Elmley Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Chronic glomerular nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 2, 1950 *to* Jan 17, 1950, *that I last saw the deceased alive on* Jan 17, 1950, *and that death occurred at* 12:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Katharine V. Kemp M. D.
23B. ADDRESS: West Balto. Gen. Hosp.
23C. DATE SIGNED: 1/17/50
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd. Balto. Md
DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: John J. Duda, Inc.
ADDRESS: 2829 Hudson St.

VS 150

V2V81

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

B-650

50 0452

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

434.3

Registered No. 50 0452

1. NAME OF DECEASED (Type or Print): VICTORIA M. BRUNO

2. DATE OF DEATH: 1/14/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-03
D. STREET ADDRESS (If rural, give location): 609 S. Lakewood Ave

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 10/23/99
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Stephen Kendryna
14. MOTHER'S MAIDEN NAME: Mary Polek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John F. Bruno — ADDRESS: 609 S. Lakewood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — Rt. sided failure

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/14, 1950, to 1/14, 1950, that I last saw the deceased alive on 1/14, 1950, and that death occurred at 9:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Charles J. Blasek M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 1/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18/50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: Timothy Williams, M.D.
25. FUNERAL DIRECTOR: John J. Duda Inc.
ADDRESS: 2824 Hudson St.

VS 150

95c

S-520

50 0453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0453

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LENORA Shanhouse

E970.2 N-971.0

2. DATE OF DEATH January 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
c. Length of stay in Baltimore 6 months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Illinois
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockford
D. STREET ADDRESS (If rural, give location) Broadway & Monument (Hopkins Hos.)

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 18, 1929
9. AGE (In years last birthday): 20 — If Under 1 Year: Months 6, Days 29, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Rockford, Illinois
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Shanhouse
14. MOTHER'S MAIDEN NAME: Louise Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-30-0490
17. INFORMANT: Mrs Leonard Shanhouse
ADDRESS: 130 Lawn Place, Rockford, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Broadway near Monument Phipps Clinic, Johns Hopkins Hospital
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan. 15, 1950 ? P.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of pills

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [X], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Carl L. Boyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Mayri
24D. LOCATION (City, town, or county) (State): Chicago, Ill.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: David Sondheim & Son
ADDRESS: 1902 Eutaw Pl.
David Sondheim & Son

VS 151

0452

162B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-622

BIRTH NO. 50 0454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 1

Registered No. 50 0454

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John D. Ferguson

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3133 Chesley Avenue
c. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-05
D. STREET ADDRESS (If rural, give location): 3133 Chesley Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 25, 1889
9. AGE (In years last birthday): 60 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P.B.X. Operator
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.
11. BIRTHPLACE (State or foreign country): Eastport, Maine
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George J. Ferguson
14. MOTHER'S MAIDEN NAME: Ellen Mc Cullough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Beatrice Ferguson, ADDRESS: 3133 Chesley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-50
24C. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [signature] Registrar, Baltimore, Md.
25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

VS 151

24298

94a

5-500

Dr. Metzer
3009 Evergreen

BIRTH NO. 50 0455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0455

1. NAME OF DECEASED (Type or Print): Laura M. Smith

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3508 Hamilton Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-04B
D. STREET ADDRESS (If rural, give location): 3508 Hamilton Avenue

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan. 7, 1878
9. AGE (In years last birthday): 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Kaufmann
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Thomas Alban
ADDRESS: 3508 Hamilton Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction Myocardium due to
DUE TO Arteriosclerotic Coronary thrombosis
(B) Uremia
DUE TO Hypertensive & V.D. - enlarged
(C) Heart - grade II - III failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral vascular accident (old)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/18, 1949, to 1/16, 1950, that I last saw the deceased alive on 1/16, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Donald W. Mintz M. D.
23B. ADDRESS: 3009 Evergreen Ave
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-50
24C. NAME OF CEMETERY OR CREMATORY: Balto National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible] for Baltimore, Md.
25. FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Road.

VS 150

5 0 0 0 4 5 1

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

A-652

BIRTH NO. 50 0456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

143

Registered No. 50 0456

1. NAME OF DECEASED (Type or Print): Jennie Kennard Armstrong

2. DATE OF DEATH: Jan. 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3132 Presstman St.,
C. Length of stay in Baltimore: 85 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3132 Presstman St.,

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 6/3/64
9. AGE (In years last birthday): 85 — If Under 1 Year: Months Days — If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Kennard
14. MOTHER'S MAIDEN NAME: Martha Newman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Hazel A. Thomas — ADDRESS: 3132 Presstman St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension & arteriosclerotic cardio-vascular disease.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Sept, 1949, *to* 15 Jan, 1950, *that I last saw the deceased alive on* 15 Jan, 1950, *and that death occurred at* 11 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil H. Henning Jr M. D.
23B. ADDRESS: 601 Winans Way
23C. DATE SIGNED: 17 Jan 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: B. Howard Strong — ADDRESS: 3207 W. North Ave.,

VS 150

0455

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

Emil N. Young Jr
1480 Edmonton
601 Winans Way.

S-152 Chas 6-1515

50 0457 Charles

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 Registered No. 50 0457

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James J. Spencer

2. DATE OF DEATH: Jan 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 301 Jeffrey St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-04
D. STREET ADDRESS (If rural, give location) 301 Jeffrey St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 18, 1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Store
10B. KIND OF BUSINESS OR INDUSTRY: self
LAST 10 YRS. WATCHMAN - FERTILIZER PLANT
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Spencer
14. MOTHER'S MAIDEN NAME: Catherine Mannion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-18-7789
17. INFORMANT: Annie M. Spencer ADDRESS: 301 Jeffrey St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 1/10, 1950, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Isaac Miller per J. Lobel M. D.
23B. ADDRESS: 1228 S. Charles St.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross G.G. Co.
24D. LOCATION (City, town, or county) (State): G. E. County Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 17 1950
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Krach Coach Serv. ADDRESS: 900 W. Chester

0456

VS 150

15661 Broadway 6666

47c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

A-141

50 0458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0458

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Etta Applefeld

2. DATE OF DEATH: Jan. 17/50

3. PLACE OF DEATH: A. Baltimore City, Maryland 3721 Gwynn Oak Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

C. Length of stay in Baltimore: 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 3721 Gwynn Oak Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1866
9. AGE (In years last birthday): 83 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Wolf
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Samuel Applefeld — ADDRESS 3801 Dorchester Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Respiratory Failure

DUE TO

(B) Congestive Heart Failure

DUE TO

(C) Arteriosclerotic CVH Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Generalized Arteriosclerotic

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948 *to* JAN 17, 1950, *that I last saw the deceased alive on* JAN 17, 1950, *and that death occurred at* 2 30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Willard Applefeld M. D.
23B. ADDRESS: 2511 Reisterstown Rd
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 18/50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): E. Baltimore St.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Sol Levinson & Bros. — ADDRESS 1124 W. North Ave.

0457

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible]

S-452

BIRTH NO. 50 0459

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

203

Registered No. 50 0459

1. NAME OF DECEASED (Type or Print): Mary Shiling

2. DATE OF DEATH: 1-17-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI Hospital
c. Length of stay in Baltimore: 47 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 3446 Park Heights ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: 1883
9. AGE (In years last birthday): 67 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Aaron Skopiso
14. MOTHER'S MAIDEN NAME: Mollie —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Dr Moses Shiling ADDRESS: 3446 Park Heights Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

ANTECEDENT CAUSES

(B) Multiple Myeloma

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-18 1949 to 1-17, 1950, that I last saw the deceased alive on 1-17 1950, and that death occurred at 10 30 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Arnold Cramer M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rosedale
24D. LOCATION (City, town, or county) (State): Balto Co.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Thurlow G. Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W. North ave

VS 150

55E

B-400

50 0460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0460

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Karen Ann Bailey

2. DATE OF DEATH: 17 Jan. 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: 1 WEEK (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. VIRGINIA
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BUCKHANNON
D. STREET ADDRESS (If rural, give location):

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): CHILD
8. DATE OF BIRTH: JULY 15, 1947
9. AGE (In years last birthday): 2 — If Under 1 Year: Months 6, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): BUCKHANNON W. VA.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: HARRY F. BAILEY
14. MOTHER'S MAIDEN NAME: KATHLEEN POLING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: UNIV HOSP. RECORDS
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain tumor

DUE TO (cystic tumor left occipital lobe)

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 17 Jan 1950
19B. MAJOR FINDINGS OF OPERATION: Cystic tumor left occipital lobe
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 Jan, 1950, *to* 17, 1950, *that I last saw the deceased alive on* 19 Jan, 1950, *and that death occurred at* 1130 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. A. Alvarez-de Choudens M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 17 Jan 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 1-17-50
24C. NAME OF CEMETERY OR CREMATORY: HEAVNER CEM.
24D. LOCATION (City, town, or county) (State): BUCKHANNON, W. VA.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: WILLIAM COOK, INC
ADDRESS: 1217 ST. PAUL ST

VS 150

0459

561

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

e-416

50 0461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0461

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Sylvester Colbert

2. DATE OF DEATH: 1-13-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 532 N. Carrollton Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 18-02
D. STREET ADDRESS (If rural, give location): 532 N. Carrollton Av.

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec. 31, 1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None CHAUFFEUR
10B. KIND OF BUSINESS OR INDUSTRY: PRIVATE FAMILY
11. BIRTHPLACE (State or foreign country): Charles Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Colbert
14. MOTHER'S MAIDEN NAME: Eliza Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Colbert
ADDRESS: 535 N. Carrollton ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular disease 8 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 12 *19*49 *to* Jan 13 *, 19*50 *, that I last saw the deceased alive on* Jan 13 *, 19*50 *, and that death occurred at* 10 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: William D. Wolf M. D.
23B. ADDRESS: 515 Washington
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 18, 1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N. Schroeder

VS 150

4286

93D

W

W-352

50 0462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

331

50 0462

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Whittington

2. DATE OF DEATH: 1-14, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 N. Stockton St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-01
D. STREET ADDRESS (If rural, give location): 806 N. Stockton St.

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 15, 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Marion Station Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Whittington
14. MOTHER'S MAIDEN NAME: Sarah J. Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elizabeth Ottingham
ADDRESS: 806 Stockton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Essential Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 9, 1950, *to* Jan 14, 1950, *that I last saw the deceased alive on* 14, 1950, *and that death occurred at* 1130 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Everson R Quein, M. D.
23B. ADDRESS: 1207 Madison Ave
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-1950
24C. NAME OF CEMETERY OR CREMATORY: W H Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Lurington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kate R. Williams
ADDRESS: 822 N. Lehman

VS 150

90651

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-650

50 0463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17

50 0463

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma H. Frome

2. DATE OF DEATH: Jan. 17/1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 1701 Casadel Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore: Yrs. Mos. Days 17)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 1701 Casadel Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 25-02 C
D. STREET ADDRESS (If rural, give location): 1701 Casadel Ave.

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 21. 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Employed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Frome
14. MOTHER'S MAIDEN NAME: Elizabeth Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Margaret Ehrhardt — ADDRESS: 1701 Casadel Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia.

DUE TO

(B) General Metastasis from

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Carcinoma uterus.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebrovascular Breast 20 yrs ago Carcinoma

19A. DATE OF OPERATION: May 48
19B. MAJOR FINDINGS OF OPERATION: hysterectomy for carcinoma
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 48, *to* Jany 17, 1950, *that I last saw the deceased alive on* Jany 16, 1950 *and that death occurred at* 8 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. McKieffer M. D.
23B. ADDRESS: 2470 Rosh Blvd
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: William Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 150

50

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

5 163

50 0464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43 50 0464

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Walter Sheppard

2. DATE OF DEATH: 1-14-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1800 Hatch St. 14-03

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 25, 1900
9. AGE (In years last birthday): 49
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Sheppard
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Pearl Sheppard
ADDRESS: 1800 Hatch St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Hypertensive cardiovascular disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO heart failure

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-13-50, 1950, *to* 1-14, 1950, *that I last saw the deceased alive on* 1-14, 1950, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. C. Beasley M. D.
23B. ADDRESS: Edward Gamble
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 18, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Beatrice Williams, M.D.
25. FUNERAL DIRECTOR: Hubbard Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

30 of 49

61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626

CERTIFICATE CORRECTED

50 0465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0465

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE ELLSWORTH PARKER

2. DATE OF DEATH: January 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2456 Brentwood Avenue
C. Length of stay in Baltimore: 31 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2456 Brentwood Avenue

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 11, 1918
9. AGE (In years last birthday): 30 31
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oden Parker
14. MOTHER'S MAIDEN NAME: Martha Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Olita P. Burrell ADDRESS: Guilford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pancreatitis

~~DUE TO~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fatty degeneration of liver

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl H. Geyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 20, 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Hunter Jr. Hillsdale, Md.
25. FUNERAL DIRECTOR: George T. A. Gibson Jr.
ADDRESS: 1631 Druid Hill Ave.

VS 151

24879 0464 128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-543

50 0466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H43

Registered No. 50 0466

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALICE HAMILTON

2. DATE OF DEATH: JAN 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1005 PARKSLEY AVE
C. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 95-52
D. STREET ADDRESS (If rural, give location): 1005 PARKSLEY AVE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: April 18, 1868
9. AGE (In years last birthday): 81
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William VAN VORST
14. MOTHER'S MAIDEN NAME: SUSANNA DELLA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARY ALICE LEE
ADDRESS: 1005 PARKSLEY AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the death of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Hypertension Cardio Vascular disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1949 *to* Jan 14th, 1950, *that I last saw the deceased alive on* Jan. 14, 1950 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Henry Glassman M. D.
23B. ADDRESS: 753 W. Fayette St
23C. DATE SIGNED: Jan 16, 50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1.18.50
24C. NAME OF CEMETERY OR CREMATORY: WESTERN
24D. LOCATION (City, town, or county) (State): BALTIMORE Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Hamilton for Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wilke
ADDRESS: 4101 Edmondson Av

VS 150

1950 0466

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

25-02-C

1

F-300

50 0467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 r

50 0467

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Foote

2. DATE OF DEATH: 1-17-1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1220 Argyle ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
C. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1220 Argyle ave.
B. COUNTY: Balto. Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 17-02
D. STREET ADDRESS (If rural, give location): 1220 Argyle ave

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 3-5-1893
9. AGE (In years last birthday): 56 — If Under 1 Year: Months 10, Days 12 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY: Barber
11. BIRTHPLACE (State or foreign country): Calvert Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Foote
14. MOTHER'S MAIDEN NAME: Sophia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Cornelius Jones — ADDRESS: 1012 Warren St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

ANTECEDENT CAUSES

(B) Chronic Nephritis — 1 yr

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11, 1950 *to* 1-17, 1950 *that I last saw the deceased alive on* 1-16, 1950 *and that death occurred at* 5:00 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Atwell Jones M. D.
23B. ADDRESS: 5-54 Dolphin St
23C. DATE SIGNED: 1-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Jan 22-50
24C. NAME OF CEMETERY OR CREMATORY: St Johns Ch
24D. LOCATION (City, town, or county) (State): Calvert Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Hamilton Ross Williams, M.D.
25. FUNERAL DIRECTOR: James A. Sayers
ADDRESS: 638 N. Gilmor St

VS 150
70089

50 0466

131B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

200

50 0468

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 982.0

50 0468

Registered No.

1. NAME OF DECEASED (Type or Print): MILFORD LEWIS

N-874.2

2. DATE OF DEATH: January 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 416 W. Franklin Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Apr. 6, 1817
9. AGE (In years last birthday): 32
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): attendant
10B. KIND OF BUSINESS OR INDUSTRY: Parking Lot
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Lewis
14. MOTHER'S MAIDEN NAME: Aileen Sykes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm. Lewis - 18 Bedford St N.J.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound right carotid artery

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 416 W. Franklin Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 16, 1950 ap. 2a.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? stabbed during altercation with wife

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Wm. Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 - 169 Druid Hill Ave.

VS 151

41684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W-256

50 0469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

41

Registered No. 50 0469

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Laura A. (Stanton) Wiseman

2. DATE OF DEATH: Jan 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5813 Simmonds ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 8 E. Hart Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 10, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Leandus Stanton
14. MOTHER'S MAIDEN NAME: Louisa Whites

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Bernhard W Wiseman
ADDRESS: 8 E Hart Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: from Rheumatic about 3 weeks

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Asthma + Bronchitis Chronic — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1950, to Jan 17, 1950 that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 3:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Walter Tuttell M. D.
23B. ADDRESS: 2220 Garrison Blvd
23C. DATE SIGNED: Jan 18 50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 20, 1950
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: P. Harold Evans
ADDRESS: 1400 S. Charles St

VS 150

0468

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-416

BIRTH NO. 50 0470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 0470

1. NAME OF DECEASED (Type or Print): Antonie Pluhar

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: 69 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13, 8-05
D. STREET ADDRESS (If rural, give location): 1660 Normal Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 16, 1863
9. AGE (In years last birthday): 86
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frank L. Pluhar, ADDRESS: 1660 Normal Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery occlusion with Myocardiac infarction

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 14, 1950 *to* Jan. 17, 1950, *that I last saw the deceased alive on* Jan. 17, 1950, *and that death occurred at* 9:20 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Sciwinski M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 20, 1950
24C. NAME OF CEMETERY OR CREMATORY: Oak Hill Cem.
24D. LOCATION (City, town, or county) (State): Horner's Lane, Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Director of Vitals, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

VS 150

0467

94a

R-361 50 0471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 no. 1

50 0471 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Ritterpusch

2. DATE OF DEATH: 1/16/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days: LIFE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 1-02
D. STREET ADDRESS (If rural, give location): 21 S. Ellwood Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH:
9. AGE (In years last birthday): 64
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10B. KIND OF BUSINESS OR INDUSTRY: DRY GOODS
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CONRAD RITTER PUSCH
14. MOTHER'S MAIDEN NAME: ANNA LEHR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-01-7615
17. INFORMANT: REV. HOWARD RITTER PUSCH ADDRESS 155 LAVERNE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. P. Turbinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 1/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: OAK LAWN
24D. LOCATION (City, town, or county) (State): COLGATE MD

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Winifred Williams, M.D.
25. FUNERAL DIRECTOR: VILLRICH FUNERAL HOME
ADDRESS: 2008 ORLEANS

VS 151 15663 0470 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

E-152

50 0472

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157

50 0472

Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL JAMES EVANS

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: 10 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 1138 May Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 48 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Coal Co
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Clarence Price — ADDRESS: 920 Low St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Pancreas
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem A.A. Co.
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: 1-18-50
REGISTRAR'S SIGNATURE: 195007469
25. FUNERAL DIRECTOR: Raymer Sanders — ADDRESS: 1442 E Preston St

VS 151

988 52

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible]

300 50 0473

50 0473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

350

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY LEE YOUSE ?420.1

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4619 Northwood Drive
C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 4619 Northwood Drive

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 24, 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vice President (rtd)
10B. KIND OF BUSINESS OR INDUSTRY: MFG. Paper Box
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian J. Youse
14. MOTHER'S MAIDEN NAME: Louisa Ebert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War #1
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Virginia D. Youse
ADDRESS: 4619 Northwood Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Postencephalitic

DUE TO

(C) Parkinsonism — 6 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 6 *19*49 *to* Jan. 17, *19*50, *that I last saw the deceased alive on* Jan 16, *19*50, *and that death occurred at* 4:30 *a. m., from the causes and on the date stated above.*

23A. SIGNATURE: Homer E. Podd M. D.
23B. ADDRESS: 2108 St Paul St
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

1561V 0472 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

432
50 0474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0474
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EVELYN KAHN GOLDSMITH

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3415 Fallstaff Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 3415 Fallstaff Rd.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Jan. 30, 1892
9. AGE (In years last birthday): 57 56 yrs. If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): New Orleans, Louisiana
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Kahn
14. MOTHER'S MAIDEN NAME: Isabelle Stern

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Louise G. Klein
ADDRESS: 3415 Fallstaff Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: about 8 mo ago

DUE TO

ANTECEDENT CAUSES

(B) Metastases to Liver — about 6 mo.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/10/49
19B. MAJOR FINDINGS OF OPERATION: Generalized Carcinomatosis - Stomach, liver, peritoneum
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/28/, 1925, *to* 1/17/, 1950 *that I last saw the deceased alive on* 1/16/, 1950, *and that death occurred at* 3.50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Theodore H. Morrison M. D.
23B. ADDRESS: 11 E. Chase St
23C. DATE SIGNED: 1/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Balto. Hebrew Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: 1-18-50
REGISTRAR'S SIGNATURE: 4500
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

0473

46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible]

0-452

50 0475

BIRTH NO. 50-011 33

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 50 0475

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Ohinger 761.5 (?)

2. DATE OF DEATH: Jan 18, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 910 Ethridge Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 16 1950
9. AGE (In years last birthday): If Under 1 Year: Months; Days: 3; If Under 24 Hours: Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Ohinger
14. MOTHER'S MAIDEN NAME: Rosemay Berneburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frederick Ohinger
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO
Premat Placenta Previa

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1/16/50
19B. MAJOR FINDINGS OF OPERATION: Cesarean Section
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/16, 1950, *to* 1/18, 1950, *that I last saw the deceased alive on* 1/18, 1950, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. H. O'Elia Jr. M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 1/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: [illegible] Registrar, Baltimore, Md.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 901 Hollins St

159

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F. 253

50 0476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0476

BIRTH NO. | 44 Registered No.

1. NAME OF DECEASED (Type or Print): Dissdado Jacundo

2. DATE OF DEATH: Jan. 15, 50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. -
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eastport -
D. STREET ADDRESS (If rural, give location): 328 - 1st St -

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 13-97
9. AGE (In years last birthday): 52 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Turisan Capiz P.I.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tumor of RUL of lung, type not identified but probably metastatic from:
DUE TO
(B)
DUE TO Undifferentiated cell carcinoma of palate
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 3, 1950 *to* Jan 15, 1950 *that I last saw the deceased alive on* Jan. 15 1950 *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edyth H. Schaurich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Nat
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Armacost ADDRESS: 5718 Guyn Oak Ave.

VS 150

0475

45c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-620 MS-128570

50 0477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0477

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Briscoe (Biscoe)

2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave
31
C. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1175 McElderry St. 502

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 1, 1910
9. AGE (In years last birthday): 39
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10B. KIND OF BUSINESS OR INDUSTRY: SURPLUS STORE
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Biscoe
14. MOTHER'S MAIDEN NAME: Evelyn Biscoe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-27- *, 19* 49 *to* 1-15- *, 19* 50 *, that I last saw the deceased alive on* 1-15- *, 19* 50 *, and that death occurred at* 1:50P *m., from the causes and on the date stated above.*

23A. SIGNATURE: B. S. Bogle M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR ~~CREMATORY~~: St. Francis
24D. LOCATION (City, town, or county) (State): Valley Lee, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Emma E. Williams M.D.
25. FUNERAL DIRECTOR: Jas. L. Mattingley
ADDRESS: Leonardtown Md

0476

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13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-436

50 0478

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E 9 16.7

50 0478

Registered No.

1. NAME OF DECEASED (Type or Print): Miss Helen Walther N-948.

2. DATE OF DEATH: 1/16/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland University Hospital Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
Spring Grove Balto Co Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bel Air
D. STREET ADDRESS (If rural, give location)

over

5. SEX: F.
6. COLOR OR RACE: Wh
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug 13-1890
9. AGE (In years last birthday): 59
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank A. Walther
14. MOTHER'S MAIDEN NAME: Anne Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Ann Dorsey
ADDRESS: Bel Air Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia due to renal — INTERVAL BETWEEN ONSET AND DEATH: 4½ days
DUE TO
(B) failure following shock
DUE TO
(C) burns by 1°, 2°, & 3° burns
85% 1° body area.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST.

R B Fisher M. D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Acc
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Spring
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Spring Grove Hosp.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 9:30 a.m. 1-12-50 Approximately m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? unknown (While emptying trash clothes became ignited

22. I hereby certify that I attended the deceased from 1/12/50, 19__, to 1/16/50, 19__, that I last saw the deceased alive on 1/16/50, 19__, and that death occurred at 8 a.m., from the causes and on the date stated above.

23A. SIGNATURE: R. Evans M. D.
23B. ADDRESS: Univ Hosp
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 1950
24C. NAME OF CEMETERY OR CREMATORY: Fork Christian Cemy
24D. LOCATION (City, town, or county) (State): Fork Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: L. E. Williams
25. FUNERAL DIRECTOR: Clarence E. Arthur
ADDRESS: Fork Md

VS 150

0477

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Letter in document file - 50-0478. 1/31/50

B-630

BIRTH NO. 50 0479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E9023

Registered No. 50 0479

1. NAME OF DECEASED (Type or Print): THOMAS C. BARRETT

N-803.2

2. DATE OF DEATH: January 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 103 S. Highland Avenue

26-08

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAR. 9, 1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months — Days —
If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN
10B. KIND OF BUSINESS OR INDUSTRY: STEEL CONSTRUCTION
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MICHAEL BARRETT
14. MOTHER'S MAIDEN NAME: MARGARET L. BARRETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): WORLD WAR I
16. SOCIAL SECURITY NO.: 231-10-0767
17. INFORMANT: MRS. JOSHUA FOWBLE, ADDRESS: LUTHERVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): steelplant
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): coalfield at steelplant at Sparrows Point, Maryland (Bethlehem)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 17, 1950 9.30 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Fell 50' from steel structure striking head on engine cylinder

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L. Page M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Mt. MARIE CEMETERY
24D. LOCATION (City, town, or county) (State): TOWSON, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: JOHN BURNS' SONS, ADDRESS: TOWSON, MD.

JAN 18 1950 316 V9 0478 186a

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible]

S-553
50 0480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 0480
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Janet Siemonds
2. DATE OF DEATH: 1-15-1950
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2299 W. Calhoun St
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 19-2
D. STREET ADDRESS (If rural, give location): 2299 W. Calhoun St.
5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 4, 1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Calif.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Weedon
ADDRESS: 2299 W. Calhoun St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3 *,* 1950 *to* 1/15 *,* 1950 *that I last saw the deceased alive on* 1/15 *,* 1950 *, and that death occurred at* 11:20 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Ralph W. Redding Jr. M. D.
23B. ADDRESS: 416 N. Howard
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Kenington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Kate R. Williams
ADDRESS: 322 N. Schroeder St

JAN 18 1950
VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-240
50 0481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 0481
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Mosley 019.7 ~~019.1~~
2. DATE OF DEATH: 1-15-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days 16

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harmons
D. STREET ADDRESS (If rural, give location): Harmons Md. Box 115 C

5. SEX: Female
6. COLOR OR RACE: negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec 11, 1924 1934
9. AGE (In years last birthday): 15
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schoolgirl
10B. KIND OF BUSINESS OR INDUSTRY: Schoolgirl
11. BIRTHPLACE (State or foreign country): Harmons Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Mosley
14. MOTHER'S MAIDEN NAME: Beatrice Chandler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Beatrice Mosley
ADDRESS: Box 115 C Harmons Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous meningitis — INTERVAL BETWEEN ONSET AND DEATH: 1 mos 16 days
DUE TO
(B) Miliary tuberculosis — 2 mos
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30, 1949, *to* 1-15, 1950, *that I last saw the deceased alive on* 1-15, 1950, *and that death occurred at* 6:55A *m., from the causes and on the date stated above.*

23A. SIGNATURE: William J. Holloway, M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-1950
24C. NAME OF CEMETERY OR CREMATORY: St. Marks
24D. LOCATION (City, town, or county) (State): Harmons Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 S. Schroeder St.

VS 150

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

H 536 50 0482

BALTIMORE CITY HEALTH DEPARTMENT 443 50 0482

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virgina Virgie A Hunter. 511632

2. DATE OF DEATH: JAN 16 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cherry Hill, ~~25-32~~
D. STREET ADDRESS (If rural, give location): 3031 ASCENSION ST. 25-32

5. SEX: Female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 6-6-93
9. AGE (In years last birthday): 56
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St Mary's Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Brooks
14. MOTHER'S MAIDEN NAME: Annie Merritt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Cerebral arteriosclerosis

DUE TO

(C) Hypertensive cardiovascular D.is

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic glomerulonephritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-31- 1949, *to* 1-16- 1950, *that I last saw the deceased alive on* 1-16- 1950, *and that death occurred at* 1:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter Orno M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: E. Virginia Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kathr R. Williams
ADDRESS: 322 N. Lombard St

VS 156

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and [illegible].

J-520

50 0483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490

50 0483

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Jones.

2. DATE OF DEATH: 1/17/50

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore (Yrs. Mos. Days): Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 915 Ryan Street 21-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: unknown 1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Weaver
14. MOTHER'S MAIDEN NAME: Caroline Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr Elmer Jones
ADDRESS: 915 Ryan St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Confluent Lobular Pneumonia - right lung

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/16, 1950 *to* 1/17, 1950, *that I last saw the deceased alive on* 1/17, 1950, *and that death occurred at* 4:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John A. Farno M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 1/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 90 Hollins St.

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-400
50 0484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41.1 50 0484
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Sohl

2. DATE OF DEATH: 1-17-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 23
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 518 S. Longwood St.

5. SEX: M
6. COLOR OR RACE: W
7. (SINGLE) MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 9/12/1882
9. AGE (In years last birthday): 67 | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10B. KIND OF BUSINESS OR INDUSTRY: Koesters Bakery
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: John Sohl
14. MOTHER'S MAIDEN NAME: Louise Sohl
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr John J. Sohl ADDRESS: 518 S. Longwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Perforated duodenal ulcer — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Aspiration pneumonia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-17-50, 19__, *to* 1-17-50, 19__, *that I last saw the deceased alive on* 1-17-50, 19__, *and that death occurred at* 10 20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Furman M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 1-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/21/50
24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Edmondson & Longwood St.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Mrs. Williams M.D.
25. FUNERAL DIRECTOR: John J. Lynan & Son
ADDRESS: Hollins St.

VS 150
300 XV FURNARI 117B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 0485 X 50 0485

T 320

BIRTH NO. 50-01137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

762.5

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Titus

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1317 Smith Ave.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Jan. 17-1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: 2 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Titus
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Edward Titus
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity c
DUE TO Congenital atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 11:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: E. Sokolski M. D.
23B. ADDRESS: St Agnes Hosp
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Frederick Ave Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mildred J. Blight
ADDRESS: 6009 Harford Rd

VS 150

159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Y-520
50 0486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443

50 0486
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER YOUNG

2. DATE OF DEATH: January 13, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore 10 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 31 Caroline Street

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 19. 1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Junk Buisness
11. BIRTHPLACE (State or foreign country): South Carolinia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Young
14. MOTHER'S MAIDEN NAME: Sarah Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: George Young
ADDRESS: 31 S. Caroline St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18/1950
24C. NAME OF CEMETERY OR CREMATORY: McCalvery Cem
24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co.md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Hunter Stockton Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantly Ave.

VS 151

0485

88 60

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G-536
50 0487

50 0487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fred Gentry

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 40 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 339 Forrest St.

5. SEX: M
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 19. 1894
9. AGE (In years last birthday): 55 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handy Man
10B. KIND OF BUSINESS OR INDUSTRY: Fish Market
11. BIRTHPLACE (State or foreign country): Amhurst Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Fred Gentry Sr.
14. MOTHER'S MAIDEN NAME: Fannie Carter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): Ware #2
16. SOCIAL SECURITY NO.
17. INFORMANT: Creed Gentry — ADDRESS: 339 Forrest St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. L. Sulowski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 20. 1950
24C. NAME OF CEMETERY OR CREMATORY: Balto. Nat. Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Thomas J. Pellegrino, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Ave

VS-115 JAN 18 1950 49661

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-360
50 0488

50 0488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Hro.1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carrie Belle Gaither

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1003 Dukeland St.
C. Length of stay in Baltimore: 3 ~~Yrs.~~ Mos. ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06.
D. STREET ADDRESS (If rural, give location): 1003 Dukeland St

5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 23 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Hobbs
14. MOTHER'S MAIDEN NAME: Ida Belle Baggell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Nellie Simmons
ADDRESS: 1003 Dukeland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

ANTECEDENT CAUSES

(B) Hypertension & Arteriosclerosis — 15 years?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO Cardio-Vascular Renal

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None done
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 12, 1942, to January 17, 1950, that I last saw the deceased alive on 1-16, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Guy Coleman M. D.
23B. ADDRESS: 1201 Poplar Grove St
23C. DATE SIGNED: 1-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 19, 1950
24C. NAME OF CEMETERY OR CREMATORY: Springfield
24D. LOCATION (City, town, or county) (State): Lyndewille, Carroll, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 18 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: C. H. West
ADDRESS: Lyndewille, Md.

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J-620
50 0489

50 0489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4 20.1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Raymond Jirsa

2. DATE OF DEATH: Jan. 17/50

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 N. Rose St.

C. Length of stay in Baltimore: 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-02
D. STREET ADDRESS (If rural, give location): 2 N. Rose St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug 3, 1900
9. AGE (In years last birthday): 49 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Jirsa
14. MOTHER'S MAIDEN NAME: Josephine Yuda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Strubin ADDRESS: 2546 E. Eager St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B) Myocardial Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-10, 1949, *to* 1-17, 1950, *that I last saw the deceased alive on* 1-17, 1950, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Vogel M. D.
23B. ADDRESS: 2644 E. Hamburg St
23C. DATE SIGNED: 1-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-50
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Lawrence Williams, M.D.
25. FUNERAL DIRECTOR: Tracy Cracchiolo
ADDRESS: 900 N. Chester

VS. 150
JAN 18 1950
27261
0480
94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 50 0490 Registered No. 50 0490

1. NAME OF DECEASED (Type or Print): JOHN W. BREWER

2. DATE OF DEATH: January 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): Belair Hotel, 611 Ensor Street

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH: 1894
9. AGE (In years last birthday): 56
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): dealer
10B. KIND OF BUSINESS OR INDUSTRY: Auto Parts
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Francis R Brewer
ADDRESS: 949 Morton St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl B. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: St Marys
24D. LOCATION (City, town, or county) (State): Hampden Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: William Cook Jr
ADDRESS: 1217 St Paul St

VS 151

15669 0489 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be correct if supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-632

50 0491
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154

Registered No. 50 0491

1. NAME OF DECEASED (Type or Print): BLANCHE SCHWARTZ

2. DATE OF DEATH: 1/19/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 2901 Norfolk Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 40 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Harris
14. MOTHER'S MAIDEN NAME: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harry Schwartz — ADDRESS: 2901 Norfolk Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pleural effusion
DUE TO
ANTECEDENT CAUSES
(B) Metastatic carcinoma
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Rectal carcinoma

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/18, 1950, *to* 1/19, 1950, *that I last saw the deceased alive on* 1/19, 1950, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Krakower M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 1/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-20-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Law
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: Mrs. Thomas, Mrs.
25. FUNERAL DIRECTOR: Jack Levin Inc
ADDRESS: 2100 Eastern Ave

VS 150

0490

467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

B-161

50 0492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 0492

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ISRAEL BOBROFSKY

2. DATE OF DEATH: 1-18-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 37 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write rural and give township): Baltimore 13 02
D. STREET ADDRESS (If rural, give location): 842 Long St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 68
If Under 1 Year: Months: Days:
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Noh Khoon
14. MOTHER'S MAIDEN NAME: Yenta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lena Bobrofsky
ADDRESS: 842 Long St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Mins.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart & Vascular Disease — 2 years

DUE TO

(C) ~~Benign Prostatic Hypertrophy~~ — ~~2-3 yrs.~~

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Benign Prostatic Hypertrophy — 2-3 yrs.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 1 18
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/9 *19*50, *to* 1/18 *19*50, *that I last saw the deceased alive on* 1/18, *19*50, *and that death occurred at* 10 15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Malcolm E. Ruben M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 1/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-50
24C. NAME OF CEMETERY OR CREMATORY: Mishkon Israel
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: Joel Lewis Inc.
ADDRESS: 2100 Eastern Pl

VS 150 360 65 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V-200

VUCH

50 0493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170.0

Registered No. 50 0493

BIRTH NO. 50-03438

1. NAME OF DECEASED (Type or Print): Baby Boy Vuch

2. DATE OF DEATH: 1-17-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Maryland.
C. Length of stay in Baltimore: one ~~Yrs.~~ ~~Mon.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN. (If outside corporate limits, write R.F.D. and give township): Baltimore - ~~297~~ 5018
D. STREET ADDRESS (If rural, give location): 257 Oakley Village

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Jan. 17, 1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days: If Under 24 Hours: Hours: 4 Min.: 37
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Emil Vuch
14. MOTHER'S MAIDEN NAME: Margaret Ellen Kelley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: Hosp For Women of Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Generalized anasarca

DUE TO

(C) Erythroblastosis Foetalis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 17, 1950 *to* Jan. 17, 1950, *that I last saw the deceased alive on* Jan 17, 1950, *and that death occurred at* 10 7 m., *from the causes and on the date stated above.*

23A. SIGNATURE: William G. Spencer, Jr. M. D.
23B. ADDRESS: Hosp. for Women of Md
23C. DATE SIGNED: 1-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/19/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem
24D. LOCATION (City, town, or county) (State): Balt, Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Chas F Evans & Son Inc
ADDRESS: 118 W Mt. Royal Ave.

VS 150

161c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D-260 (522833)

50 0494

BIRTH NO. 50-00915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

762.0

50 0494

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Dozier

2. DATE OF DEATH: January 15, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2522 Druid Hill Avenue

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: January 15, 1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days; If Under 24 Hours: Hours: 1 Min.: 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frances Dozier
14. MOTHER'S MAIDEN NAME: Helen Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs 20 mins

DUE TO

(B) aspiration of meconium

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 15, 1950 *to* January 15, 1950, *that I last saw the deceased alive on* January 15 1950, *and that death occurred at* 5:20 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: William L. Hartmann M. D.
23B. ADDRESS: 601 N. Broadway
23C. DATE SIGNED: January 17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Hof Deerfield
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: Martin J. Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

0493

VS 150

160c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L-520

50 0495
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

442

Registered No. 50 0495

1. NAME OF DECEASED (Type or Print): Mary Lohnes

2. DATE OF DEATH: Jan.17/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2006 E.Madison St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 2006 E.Madison St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
D. STREET ADDRESS (If rural, give location): 2006 E.Madison St.

5. SEX: Feamle
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct.21,1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: HO
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Lunz
14. MOTHER'S MAIDEN NAME: Barbara Bergman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Wm.Lohnes, ADDRESS: 2006 E.Madison St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Cardio Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

DUE TO

ANTECEDENT CAUSES

(B) General Arterio Sclerosis — —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uterine Fibroid Tumors — 10 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): January 17, 1950 1:30 p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1940, to January 17, 1950, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE: Frank J. Ayd M. D.
23B. ADDRESS: 2005 E. Monument St
23C. DATE SIGNED: Jan 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan.20/50
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Philip Herwig Sons, ADDRESS: 2024 Orleans St.

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully. MARGIN RESERVED FOR BINDING

D-340

BIRTH NO. 50 0496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

E981

Registered No. 50 0496

1. NAME OF DECEASED (Type or Print): Wilbur Biddle N-875.4

2. DATE OF DEATH: Jan. 16, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1211 Edmondson Ave. 18-02

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 2-21-1933
9. AGE (In years last birthday): 16 — If Under 1 Year: Months 10, Days 26 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Huckster's Helper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Biddle
14. MOTHER'S MAIDEN NAME: Lenora Biddle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mildred Watkins — ADDRESS: 1211 Edmondson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemothorax left — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Gun shot wound, left chest
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Cellar of - - - - - - - -
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 609 W. Lanvale St.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan. 16, 1950 6 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [ ], *accident* [ ], *suicide* [ ], *homicide* [X], *undetermined* [ ].

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Jan. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 1-20-50
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
24D. LOCATION (City, town, or county) (State): A.A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: Katherine M. Williams, M.D.
25. FUNERAL DIRECTOR: Samuel W. Sullivan, Jr.
ADDRESS: 1011 N. Arlington Ave

VS 151 49661 166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 0497

BIRTH NO. 50 0497

1. NAME OF DECEASED (Type or Print): Dr. Harold E. Wright

2. DATE OF DEATH: Jan. 16/50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1203 Roundhill Rd.
C. Length of stay in Baltimore ~~Life~~ 30 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-02
D. STREET ADDRESS (If rural, give location): 1203 Roundhill Rd.

5. SEX: Male
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 23, 1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Wright
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Louise S. Wright, ADDRESS: 1203 Roundhill R

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral anoxemia — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Myocardial infarction — 1½ hr.

DUE TO

(C) Coronary arteriosclerosis — 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — Hypertension. — ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* — , 1949, *to* Jan. 16, 1950, *that I last saw the deceased alive on* Jan. 16, 1950, *and that death occurred at* 10:10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robt. B. Wright M. D.
23B. ADDRESS: Medical Arts Bldg.
23C. DATE SIGNED: Jan. 18, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 19/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk.
24D. LOCATION (City, town, or county) (State): 3801 Frederick Rd. Baltimore, 29 Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Harry A. Little
ADDRESS: 4101 Edmondson Ave.

VS 150 V3292

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W# 326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161

Registered No. 50 0498

BIRTH NO. 50 0498

1. NAME OF DECEASED (Type or Print): WILLIAM P. WHITAKER

2. DATE OF DEATH: Jan. 18, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1521 Pentridge Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1521 Pentridge Rd.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 3, 1885
9. AGE (In years last birthday): 64 yrs. If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker
10B. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Anderson, South Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph T. Whitaker
14. MOTHER'S MAIDEN NAME: Elizabeth Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): –
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Elizabeth D. Whitaker
ADDRESS: 1521 Pentridge Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma? Larynx
DUE TO
Hemorrhage

ANTECEDENT CAUSES

(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C) Recent Severe Cervical Neuritis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/8, 1948, *to* 1/18, 1950, *that I last saw the deceased alive on* 1/14, 1950, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter A Baetjer M. D.
23B. ADDRESS: 1101 St Paul St
23C. DATE SIGNED: 1/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Green Mount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: Huntington Williams
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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1-520

50 0499
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170

50 0499
Registered No.

1. NAME OF DECEASED (Type or Print): HELEN A. LONG

2. DATE OF DEATH: Jan. 17, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3407 Piedmont Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-08A
D. STREET ADDRESS (If rural, give location): 3407 Piedmont Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 11, 1885
9. AGE (In years last birthday): 64 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Williamsport, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Hughes
14. MOTHER'S MAIDEN NAME: Margaret Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Ellsworth L. Long
ADDRESS: 3407 Piedmont Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno-Carcinoma (Breast) — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) Coronary Sclerotic Heart Disease — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: - 1947.
19B. MAJOR FINDINGS OF OPERATION: - Adeno-Carcinoma of Breast.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 13, 19~~49~~ 50 *to* Jan. 17, 1950, *that I last saw the deceased alive on* Jan. 16, 1950 *and that death occurred at* 1 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl J. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts.
23C. DATE SIGNED: 1/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/20/50
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E 430 B.C. 50-00106

MS--134743

50 0500

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

76210

Registered No. 50 0500

1. NAME OF DECEASED (Type or Print): Baby Boy Ellett

2. DATE OF DEATH: 1-11-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore (Yrs. Mos. Days): life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1426 E. Chase St.

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 5, 1950
9. AGE (In years last birthday): If Under 1 Year: Months: Days: 6 Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Norman E. Ellett
14. MOTHER'S MAIDEN NAME: Frances Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records--Baltimore City Hospitals
ADDRESS: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Neonatal anoxia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5- *, 1950, to* 1-11- *, 1950, that I last saw the deceased alive on* 1-11- *, 1950, and that death occurred at* 7:20 Pm. *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 1-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 1-13-50 @2PM
24C. NAME OF CEMETERY OR CREMATORY: B.C.H. Crematory
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

0429

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and fully.